



The Mississippi Asthma and Anaphylaxis Child Safety Act

Legal Definitions & Life-Saving Decisions

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For more than a decade, the Terence E. Downer Scholarship has supported pharmacy students at the University of Mississippi. The endowment honors Terence E. Downer, who died April 25 after a short battle with cancer, and will benefit the school in perpetuity. Scholarships from the endowment are awarded annually to students pursuing careers in pharmaceutical marketing. A committee of faculty members from the School of Pharmacy's Center for Pharmaceutical Marketing and Management and Department of Pharmacy Administration selects the recipients.

Executive Summary

Under existing state law, auto-injectable epinephrine is the only form of epinephrine approved for use in Mississippi public schools, and the law fails to designate a decision-maker responsible for making a school's decision to stock epinephrine. We propose amending Mississippi Code Title 37. Education § 37-11-71, also known as the Mississippi Asthma and Anaphylaxis Child Safety Act, to redefine "anaphylaxis medication" to include additional FDA-approved forms of epinephrine. Further, we support naming school nurses and school principals as anaphylaxis decision-makers. Expanding epinephrine delivery options for Mississippi schools may encourage increased adoption of state-required anaphylaxis policy to protect the lives of Mississippi children.

Background

Anaphylaxis is a severe, life-threatening allergic reaction most often caused by food, medicine, or insect venom, and can cause death in less than 15 minutes via airway swelling, loss of consciousness, cardiac arrest, or respiratory failure.¹⁻³ Nationally, there is an anaphylaxis-related pediatric fatality rate estimated between 0.65% and 2%.⁴ And in Mississippi, where children make up about 20% of the population, 53% of anaphylaxis-related insurance claims are in patients ages 0-18 years old.^{5,6}

Anaphylaxis Is A Life-Threatening Allergic Reaction And Can Cause Death In Less Than 15 Minutes.¹⁻³

On average, at least one child in every U.S. classroom has a food allergy, and 40% of that group have multiple food allergies.^{7,8} Given this prevalence, school reactions are not uncommon. A 2005 study of 109 Massachusetts school districts reported 115 anaphylactic reactions in two years.⁹ Notably, 25% of anaphylactic reactions occurred in students with no prior diagnosed allergy.¹⁰ A similar story was found in a 2014 study of Chicago public schools that reported 21 anaphylactic reactions in undiagnosed children in one year.¹¹

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Epinephrine is the first line treatment for anaphylaxis and must be administered promptly to be effective.¹² However, epinephrine is only carried by students with a pre-existing diagnosis. Without an anaphylactic allergy diagnosis, the 1-in-4 children experiencing an anaphylactic reaction at school face no life-saving treatment options, risking fatal outcomes, unless one of the following occurs:

- (1) the school nurse or trained school employee uses another child's prescribed epinephrine leaving the school district responsible for replacing the ~\$700 used epinephrine, or
- (2) the school nurse or trained school employee uses epinephrine provided to the school free-of-charge through pharmaceutical school programs that also provide free replacements.^{13–15}

Option 2 is cost avoidant, and Mississippi law allows for it. The Mississippi Asthma and Anaphylaxis Child Safety Act, passed in 2014, mandates that public school districts and their school boards allow each school to maintain a supply of undesignated epinephrine.¹⁶ Undesignated epinephrine is prescribed by a licensed physician or Mississippi Department of Health officer and issued to the school district or individual school. However, a review of epinephrine policies in Mississippi public schools shows that school districts often do not consider option 2.

Findings

In September 2026, we reviewed the 141 Mississippi school district policy manuals and handbooks for epinephrine policies (Addendum A). The review revealed that only 5 schools had policies that explicitly stated they stock undesignated epinephrine, and only 33% of school boards have adopted the entire state-mandated policy. Comparative content analysis of the state law versus school policies shows that a lack of specificity on epinephrine delivery and ambiguity around decision-making may have left schools without a clear direction on whether to stock and administer undesignated epinephrine.

DRUG ADMINISTRATION LANGUAGE

Mississippi law specifies “auto-injectable epinephrine” and defines “anaphylaxis medication” as auto-injectable epinephrine.¹⁶ School policies make the same distinction; some even specifically refer to the brand name, EpiPen.

Yet, the method of epinephrine delivery is not incidental, but of vital importance in a primary and secondary school setting. A 2022 study showed significant delays in administering auto-injectable epinephrine due to fear of needles, even when administered by physicians.¹⁷ Delays in epinephrine administration are more likely to lead to poor neurological and fatal outcomes than when epinephrine is administered within five minutes.^{18,19} Neffy – an epinephrine nasal spray – has proven to be more accessible and effective¹⁵ and provides four free nasal sprays to any school with a prescription.¹⁴ However, the nasal spray delivery-method is currently not permitted in Mississippi schools under the current “auto-injector”-specific language.

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ANAPHYLAXIS DECISION-MAKING

Mississippi law mandates that the “school board” allow each “school” to maintain a supply of auto-injectable epinephrine but does not specify who within the school should make that decision.¹⁶ Decision-making ambiguity leads to the bystander effect, which is the lack of responsibility felt by any individual person in a group, causing everyone to wait for another person to act.²⁰

Mississippi law extends the right to administer undesignated epinephrine to the “school nurse or trained school employee.”¹⁶ Studies recognize school nurses as the most knowledgeable about school anaphylaxis policies and what is needed in their schools to reduce allergen exposure and manage anaphylaxis.²¹ However, school nurses are often not in control over those decisions.²¹

Recommendation

Amend Mississippi Code Title 37. Education § 37-11-71, to:

- ▶ Redefine “anaphylaxis medication” as “any Food and Drug Administration approved form of premeasured epinephrine used to administer epinephrine into the human body to prevent or treat a life-threatening allergic reaction,” (language derived from Alabama HB533, passed April 2026²²), and remove the words, “auto-injector” and “auto-injectable.”
- ▶ Include a section stating, “The school nurse is authorized to determine whether the school stocks undesignated epinephrine for use in the event of an anaphylactic emergency. In schools without a school nurse, this decision rests with the school principal.”
- ▶ Epinephrine decision-makers will also need to be included in the civil liability protection clause.

Conclusion

Amending the legal definitions of the Mississippi Asthma and Anaphylaxis Child Safety Act may seem like a minor policy change, but when dealing with anaphylaxis-related pediatric fatality every minor detail counts. This small change could allow Mississippi schools access to more effective treatment options, empower knowledgeable medical professions with defined decision-making ability, and improve the odds for Mississippi school children who have undiagnosed anaphylactic allergies.

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About the Author



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