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Food Allergy Policy in the Israeli School System: Time for a Change?

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Food Allergy Policy in the Israeli School System: Time for a Change?

Sarit Silverman and Nadav Davidovitch

Introduction

Over the past two decades, Israel has experienced a rise in prevalence of IgE-mediated food allergies[1] among young children, growing from 0.85% in 2000 to 2.8% by 2018 (Dalal et al., 2002; Garkaby et al., 2021). Food allergy has also been increasing in other high-income countries in recent decades, though cross-national comparison should be treated with caution, as prevalence studies differ widely in methodology and definition (Garkaby et al., 2021; Nachshon et al., 2019; Prescott et al., 2013). The rise of food allergies is suggested to be driven by multiple interacting factors, including the hygiene hypothesis, which asserts that reduced early-life microbial exposure dysregulates immune development, and shifts in dietary patterns, such as increased consumption of processed foods (Bahna, 2024). Prevalence in Israel remains lower than in other high-income countries, driven largely by an exceptionally low rate of peanut allergy (0.2%)—in contrast to most high-income countries where peanut allergy is among the most common food allergies (Bahna, 2024; Garkaby et al., 2021; Nachshon et al., 2019). The lower prevalence is widely attributed to early childhood exposure in Israel to Bamba, a peanut-based snack consumed from infancy (Du Toit et al., 2008).

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1 IgE-mediated food allergy—the form that can cause anaphylaxis, and the form Israeli school policy addresses—is a condition in which the body produces IgE antibodies against a specific food. Diagnosis requires evidence of sensitization by skin prick or blood testing, together with a history of reaction to that food or a positive oral food challenge (Elizur et al., 2026).

Food allergy policy in the Israeli school system is based on the Ministry of Education's Permanent Directive 0042, which establishes a comprehensive safety framework for students with "life-threatening food allergies" (Ministry of Education, 2017).[2] All parents are required to complete an annual health declaration form in which they are asked to report any allergies or sensitivities their child has, as well as whether their child requires an epinephrine auto-injector (hereafter EpiPen), in which case parents are required to deposit one at the school. In addition, children with "life-threatening food allergies" are entitled to a dedicated medical assistant (סייעת רפואית) from preschool through grade 2, contingent on a letter from a specialist documenting an IgE-mediated allergy to one of six specific foods (milk, peanuts, sesame, nuts, eggs, or fish). Additional measures include mandatory annual staff training in recognizing allergic reactions and administering epinephrine, school-wide bans on the declared allergen from school premises, and a requirement that the student's EpiPen be carried on all off-site activities.

Implementation of these guidelines has placed growing demands on the education system. Blanket food bans, absent prior to the 2017 directive, are now in place in approximately half of all primary schools (Knesset, 2025). The number of approved medical assistants has nearly doubled, from 4,655 in 2020/21 to 8,676 in 2024/25 (Knesset, 2025; Mayzel, 2025), representing a significant and growing budgetary commitment. In the 2024/25 school year, the total budget allocated to medical assistants for food allergy students alone reached NIS 523 million (Moshe, 2026). Yet compliance in other aspects remains a challenge: Ministry of Health inspections found that in 27% of schools inspected, EpiPen availability was either absent or incomplete (Mayzel, 2025). A further concern is unequal access. The medical assistant entitlement requires a specialist's letter, yet allergist availability in Israel is limited (Elizur et al., 2026), and international research finds that children from lower-income families face barriers to diagnosis and are significantly less likely to be prescribed an EpiPen (Coombs et al., 2011). Children who are undiagnosed are ineligible, and the policy may therefore leave underserved children without protection.

2 The term "life-threatening food allergies," used in the Ministry of Education directive, is considered misleading by allergy specialists, who argue that it contributes to public misconceptions about food allergy management and prefer the term "IgE-mediated food allergy" (Elizur et al., 2026).

Where other countries have adopted targeted restrictions such as peanut-free zones, Israel's policy is the most extensive and expansive. Two policies in particular, school-wide food bans and medical assistants, have no parallel elsewhere and likely stem from unique features of the Israeli education system. On-site school nurses were eliminated in the 1990s. In the decades since, rising food allergy rates increased the likelihood of anaphylactic episodes occurring in school settings, so that medical need grew precisely as the capacity to meet it disappeared, leaving Israeli schools without the trained medical personnel that schools in other countries can rely on. Israeli schools also lack cafeterias or designated eating areas; students eat in their classrooms, making allergen exposure possible in the learning environment itself.

Both of these policies—the implementation of school-wide food bans and the provision of medical assistants—reflect a genuine commitment to student safety, yet each raises its own concerns. Major international allergy associations, including the American Academy of Pediatrics and the Israel Association of Allergy and Clinical Immunology, recommend against blanket food bans in the school environment for several reasons (BSACI, 2024; Elizur et al., 2026; Higgs et al., 2021; Sicherer et al., 2010; Vale et al., 2015; Waserman et al., 2021). They argue that there is no documented evidence that such bans reduce anaphylactic reactions, and that they create a false sense of security, since children continue to bring allergenic foods to school, particularly unmarked or home-prepared foods. Bans also fail to teach allergic students the self-management skills they will need (Muraro et al., 2014; Sicherer et al., 2010), while imposing nutritional burdens on non-allergic children prevented from bringing basic foods. Finally, they can generate interpersonal conflict and have been associated with bullying of the very children they are meant to protect.

The medical assistant program, unique to Israel, has no research base against which its effectiveness can be evaluated. Its rationale is to increase supervision of young children who cannot self-manage. However, evidence shows that anaphylaxis mortality risk is highest not among young children, but among adolescents (Baseggio Conrado et al., 2021; Pouessel et al., 2018), meaning this age-targeted policy allocates protective resources to one age group while leaving the most vulnerable group exposed. The program's design raises an additional concern about effectiveness: assistants receive only basic medical instruction and no educational training whatsoever. Thus, a substantial investment is made that places, on a daily basis, adults who are minimally

prepared for the medical role they are assigned and largely unequipped to contribute to the educational setting they occupy.

To summarize: the food ban policy in the Israeli school system is at odds with medical research and recommendations and has proven difficult to implement effectively, and the medical assistant program is highly costly and inconsistent with what is known about age-related risk. As food allergy prevalence rises, they have become an increasingly consequential part of daily life for Israeli families in general, whether or not they have a child with an IgE-mediated allergy.

In this study, we take advantage of data from parents' mandatory annual health declarations to track these trends across the Israeli education system, focusing on two key measures: sensitivity declarations and EpiPen carriage. We look at trends in each of these measures and assess their uniformity across educational stages, subpopulations and socioeconomic status (SES). Our findings bring evidence to bear on both the sustainability and the equity of the current policy.

Methods

Data sources

Allergy and EpiPen carriage data were obtained via a Freedom of Information request to the Ministry of Education, based on responses to the annual parental health declaration form, covering the 2021/22–2024/25 school years. The declaration form includes two questions relevant to this study: "Does the student have sensitivities to food or other substances?" (yes/no, with a checklist of specific allergens if yes); and "Does the student carry a personal epinephrine auto-injector (EpiPen)?" (yes/no). Neither question is restricted to food allergy; approximately 86% of parent-reported sensitivities are food-related, with the remainder reflecting sensitivities to non-food substances such as insect stings.[3]

Data were provided in three separately aggregated files: two files containing sensitivity declarations and EpiPen carriage respectively, each aggregated by local authority (*reshut*), socioeconomic cluster (*eshkol*), grade, and school year; and a third file containing EpiPen carriage by sector (*migzar*), supervisory authority (*pikuach*), grade, and school year, used for group-level analyses. EpiPen carriage data across both files were available from 2022/23 onward;

3 Calculated from supplementary data provided by the Ministry of Education.

2021/22 data are therefore presented for sensitivity declarations only. Equivalent data by migzar and pikuach for sensitivity declarations were not available. Since socioeconomic and group-level data derive from separate aggregations, simultaneous analysis of SES and population group was not possible. Cell counts below five are suppressed in the aggregated data, recorded as "fewer than five;" suppressed values were imputed as three throughout.[4] School enrollment data, used as population denominators, were drawn from the Ministry of Education's Wide Perspective database, which provides detailed information on student enrollment in Israeli educational institutions. Enrollment figures were matched to declaration data by local authority, grade, school year, and where applicable, socioeconomic cluster, supervisory authority, and sector.

Main outcome measures

Three measures were derived from the declaration data. Allergy and sensitivity declaration rates and EpiPen carriage rates were calculated by dividing declaration counts by the corresponding enrolled student population, matched by all available grouping variables. For brevity, we refer to the first variable throughout as sensitivity rates and the second as EpiPen rates. Local authority-year-grade combinations present in the enrollment data but absent from the declaration files were assigned zero counts, ensuring that all localities are included in the analysis. A third measure, declaration ratio, was defined as EpiPen rate as a percentage of sensitivity rate, matched by all available grouping variables, capturing the share of sensitivity declarations accompanied by EpiPen carriage. One local authority in which EpiPen carriage was recorded but sensitivity declarations were absent was excluded from the analyses as this represents an implausible data entry.

4 To assess the sensitivity of our findings to this imputation, we examined national trends under three assumptions: all suppressed values coded as 1 (minimum), 3 (midpoint), or 5 (maximum). Trends were consistent across all three scenarios, and we therefore report results using midpoint imputation throughout.

Grouping variables

Educational stage

Analyses were restricted to grades 1–12; preschool was excluded as data were available only for 2024/25, and declaration counts for that year indicate incomplete coverage. Grades were grouped into four educational stages: early primary (grades 1–2), late primary (grades 3–6), middle school (grades 7–9), and high school (grades 10–12). Early primary was distinguished from late primary as grades 1–2 are covered by the medical assistant entitlement. Educational stage rates were calculated by summing declaration counts and enrollment counts across the grades within each educational stage prior to rate calculation, preserving enrollment-weighted estimates.

Local SES (Eshkol)

Socioeconomic status was measured using eshkol, a CBS indicator that categorizes local authorities into 10 hierarchical levels based on income, education, and employment, with level 1 representing the lowest and level 10 the highest. Eshkol coding was inconsistent across files for four local authorities; these were assigned a single value based on cross-file inspection and CBS classifications. Since clusters 9 and 10 are substantively similar high-SES groups, and cluster 1 contains only eight local authorities, clusters 9–10 and clusters 1–2 were each collapsed into single categories for all analyses.

Educational stream

Population group was defined by combining sector (migzar) and the school's supervisory authority (pikuach) codes into a single variable representing six educational streams in the Israeli school system: Hebrew State, State-religious, Haredi, Arab, Bedouin, and Druze. This classification assumes that students generally attend schools aligned with their family identity. A seventh group, Circassian ($n \approx 550$), was excluded due to insufficient sample size. As noted above, group-level analyses are restricted to EpiPen rates only.

Analytic approach

Given the short time frame and aggregate nature of the data, analyses are descriptive, mapping trends in sensitivity, EpiPen, and declaration ratios across educational stage, socioeconomic status, and educational stream.

Results

National trends

Table 1 presents the growth in sensitivity and EpiPen rates across the Israeli school system between the 2021/22 and 2024/25 school years. Sensitivity rates more than doubled from 1.22% in 2021/22 to 2.52% in 2024/25, while EpiPen rates rose from 0.37% in 2022/23 to 0.53% in 2024/25. To contextualize the scale of this growth, while total student enrollment grew by an average of 1.8% per year, the number of sensitivity declarations grew by 16%–17% annually and EpiPen declarations by 20% annually over the same period. Declaration ratios remained broadly stable throughout the period, ranging from 19.7%–21%, suggesting that EpiPen declarations kept pace with the growth in sensitivity declarations.

Table 1. National trends in sensitivity declarations

Israeli school system (grades 1–12)

School year	Total students	Sensitivity rate		EpiPen rate		Declaration ratio
		N	Percent of all students	N	Percent of all students	
2021/22	1,902,613	23,294	1.22%	—	—	—
2022/23	1,947,545	37,153	1.91%	7,302	0.37%	19.65%
2023/24	1,977,179	43,539	2.20%	8,722	0.44%	20.03%
2024/25	2,009,341	50,571	2.52%	10,619	0.53%	21.00%

Note: EpiPen data for 2021/22 is excluded as the carriage declaration system was not yet operational. Rates are calculated against total enrolled students in each year. The final column is the share of students with a personal EpiPen carriage out of those with a declared sensitivity.

Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

Trends by educational stage

Sensitivity rates rose consistently across all educational stages between 2021/22 and 2024/25, with early primary rates falling below those of late primary and middle school from 2023/24 onward (Figure 1). EpiPen rates and declaration ratios show a different pattern (Figures 2 and 3, respectively). Early primary students show the highest EpiPen rate across all educational stages in every year (0.47% in 2022/23, rising to 0.64% by 2024/25) and the highest declaration ratio (24% in 2022/23, rising to 26% in 2024/25). Both measures drop markedly from grade 3 onward, a pattern consistent with the medical assistant entitlement, which applies exclusively to grades 1–2 and provides families with a direct policy incentive to ensure that declarations and EpiPen carriage are formally documented.

SES trends

Sensitivity rates showed a steep and consistent socioeconomic gradient across all years. In 2021/22, sensitivity rates ranged from 0.28% in the lowest SES cluster (eshkol 1–2) to 3.21% in the highest (eshkol 9–10)—an approximately 11-fold difference (Figure 4). By 2024/25 this gap had widened in absolute terms, with eshkol 1–2 reaching 0.65% and eshkol 9–10 reaching 5.06%. EpiPen rates showed a similar trend: in 2022/23, rates ranged from 0.08% in eshkol 1–2 to 0.86% in eshkol 9–10, rising to 0.12% and 1.10% respectively by 2024/25 (Figure 5). Given the lower allergy and EpiPen rates in lower-SES localities, one might expect to find higher declaration ratios assuming only the most severe cases are declared there; however, declaration ratios showed no consistent SES gradient, with median rates broadly similar across clusters (Figure 6). This suggests that the ratio of EpiPen to sensitivity declarations is relatively stable across SES levels.

Figure 1. Sensitivity rate by educational stage

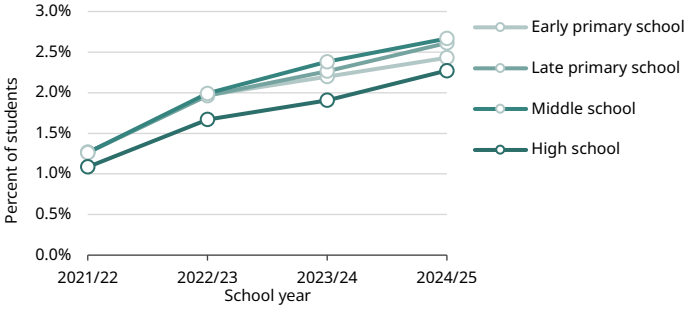


Figure 2. EpiPen rate by educational stage

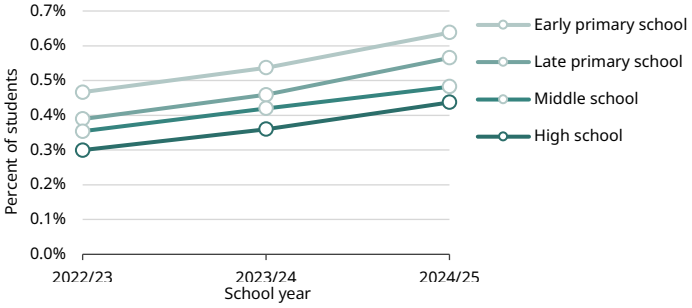
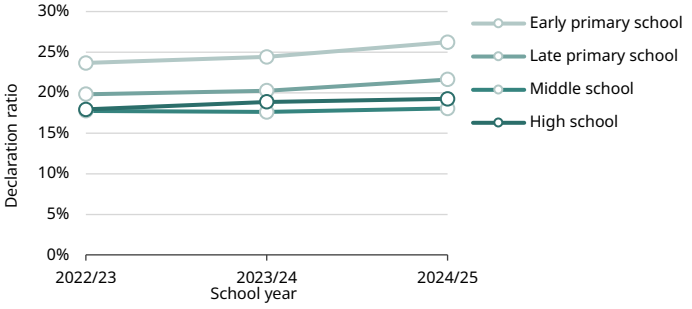
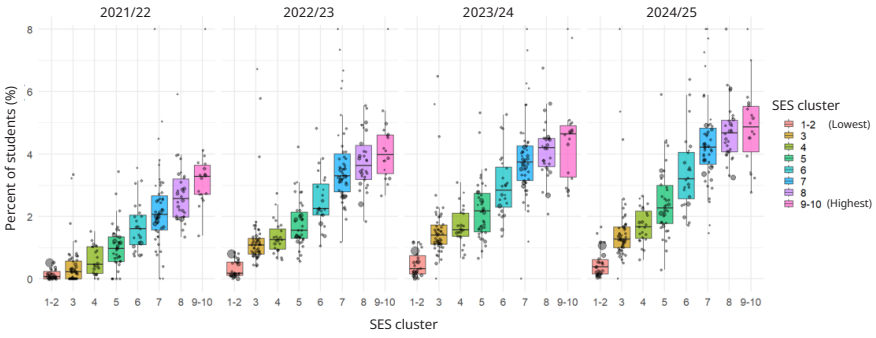


Figure 3. Declaration ratio by educational stage



Source for Figures 1–3: Sarit Silverman and Nadav Davidovitch, Taub Center | Data for Figures 1–3: Ministry of Education, Freedom of Information Law

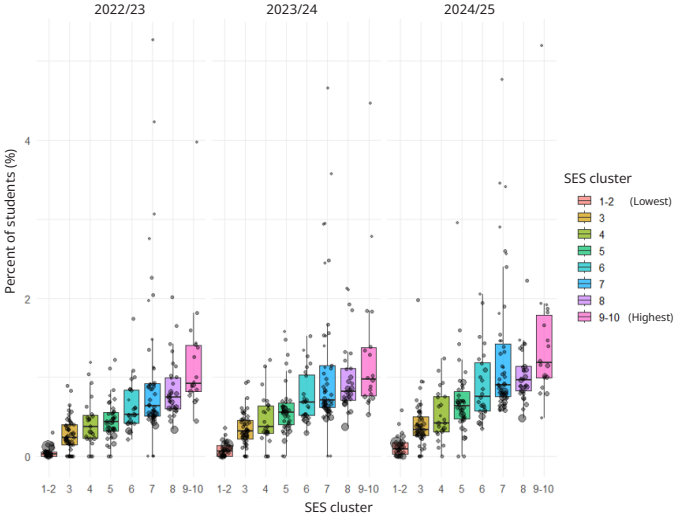
Figure 4. Sensitivity declaration rate by socioeconomic cluster



Note: Each dot represents one local authority (reshut), sized proportionally to student enrollment.

Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

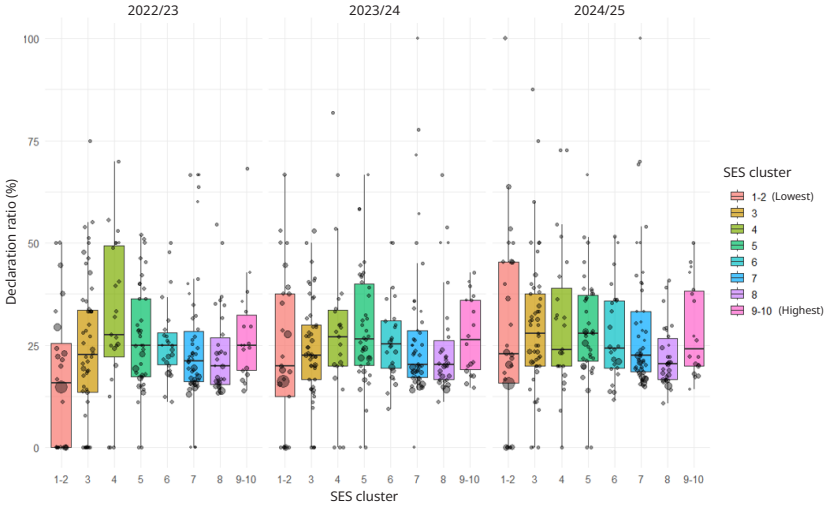
Figure 5. EpiPen carriage rate by socioeconomic cluster



Note: Each dot represents one local authority (reshut), sized proportionally to student enrollment.

Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

Figure 6. Declaration ratio by socioeconomic cluster



Note: Each dot represents one local authority (reshut), sized proportionally to student enrollment.

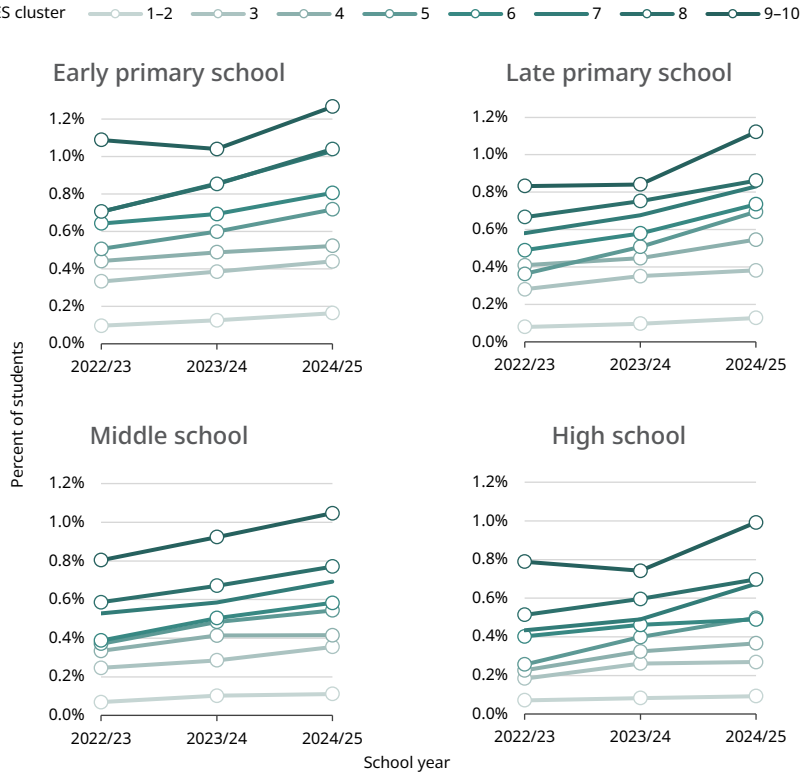
Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

EpiPen carriage by socioeconomic cluster and educational stage

To examine the relationship between the early primary elevation in EpiPen rates and SES, we compared EpiPen rates across educational stages within each SES cluster (Figure 7). A clear SES gradient was present across all educational stages—in every stage, eshkol 9–10 localities showed the highest rates and eshkol 1–2 the lowest. The gap between SES clusters was largest in early primary: eshkol 9–10 localities declared EpiPen carriage at 1.09% in 2022/23 compared to 0.10% in eshkol 1–2, rising to 1.27% and 0.16% respectively by 2024/25. In eshkol 1–2, differences across educational stages were negligible, and EpiPen rates at every stage were far below those in eshkol 9–10.

This suggests that the policy incentive created by the medical assistant entitlement operates almost exclusively in higher SES communities, with negligible effect in the lowest SES localities.

Figure 7. EpiPen carriage rate by socioeconomic cluster and educational stage

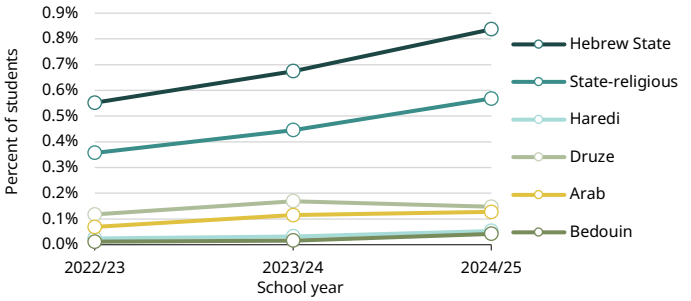


Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

Trends by educational stream

As sensitivity declaration data were not available by educational stream, this section focuses on EpiPen rates only. EpiPen rates varied markedly by educational stream (Figure 8): rates were highest in the Hebrew State stream across all three years, rising from 0.55% in 2022/23 to 0.84% by 2024/25, followed by State-religious from 0.35% to 0.57%. All other streams remained below 0.2% throughout the period. The gap between these two streams and the remaining streams widened from 2022/23 to 2024/25.

Figure 8. EpiPen carriage rate by educational stream

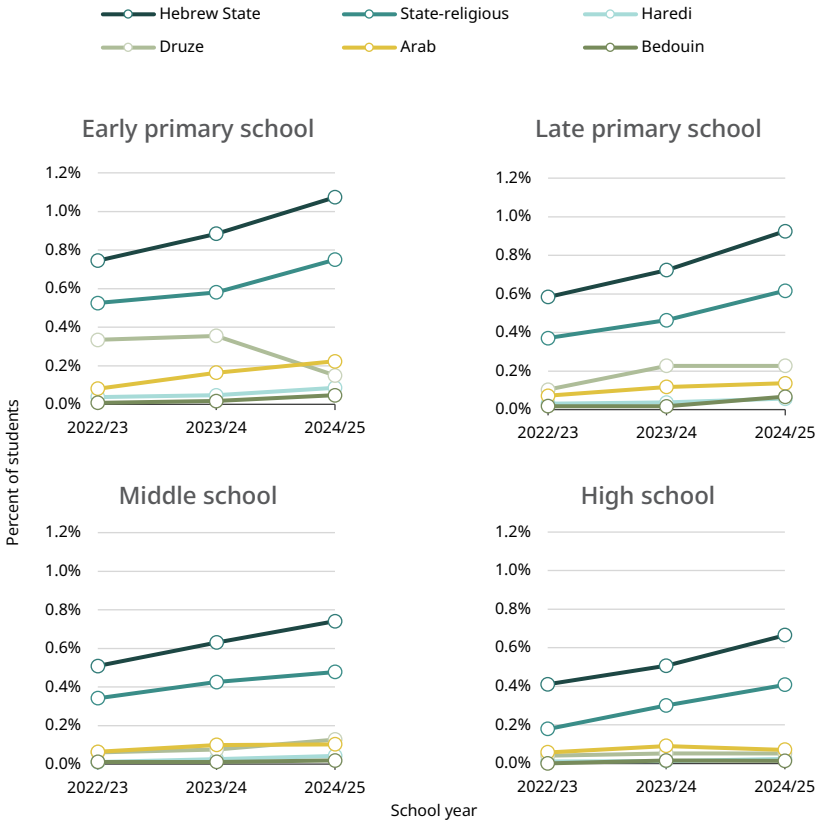


Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

Examining these patterns by educational stage, Hebrew State and State-religious showed the highest and most rapidly growing EpiPen rates across every educational stage, while the other streams remained low and largely flat throughout (Figure 9). A clear elevation in early primary EpiPen rates relative to later educational stages is visible only in the Hebrew State and State-religious streams; in every other stream, rates are similar across educational stages.[5] This suggests that the policy incentive created by the medical assistant entitlement is operating almost exclusively within Hebrew State and State-religious institutions, with no equivalent effect detectable in other streams.

5 Druze showed a similar early primary elevation in 2022/23 and 2023/24 but rates declined sharply in 2024/25, likely reflecting small sample size (approximately 31,000 students total).

Figure 9. EpiPen carriage rate by educational stream and stage



Source: Sarit Silverman and Nadav Davidovitch, Taub Center | Data: Ministry of Education, Freedom of Information Law

Discussion

Since the updated food allergy policy in the school system (2017) was implemented, the demands placed on the education system have grown considerably. This study tracks the rise of sensitivity declarations and EpiPen carriage in the Israeli school system using data from the Ministry of Education's mandatory annual health declaration, covering the 2021/22 to 2024/25 school years. Both measures grew nationally, with sensitivity rates more than doubling from 1.22% in 2021/22 to 2.52% in 2024/25 and EpiPen rates rising from 0.37% in 2022/23 to 0.53% in 2024/25. Both grew far faster than the student population. These findings are consistent with the global trend of rising food allergy prevalence, but the magnitude of growth over a short time period suggests that there is an additional effect of policy-related incentives.

Examining trends by educational stage, EpiPen rates and declaration ratios were markedly higher among early primary students (grades 1–2) than in all other stages, while sensitivity rates showed no such difference. This stage-based difference in EpiPen and declaration ratios may partly reflect genuine clinical variation, as some allergies resolve in early childhood and some children undergo oral immunotherapy that reduces reliance on EpiPen carriage. However, if natural resolution were the primary driver of this stage-based reduction, we would expect sensitivity rates to be elevated among early primary students, reflecting the population of children who have not yet outgrown their allergy. The data, however, show no such elevation, with early primary sensitivity rates comparable to or below those of later stages. A more likely explanation, therefore, is that the medical assistant entitlement, which applies exclusively to grades 1–2, provides families with an incentive to ensure EpiPen carriage is reported in this stage more than others, resulting in a higher declaration ratio. Qualifying for the entitlement requires more than declaring EpiPen carriage: parents must also submit a specialist letter documenting an IgE-mediated food allergy to one of six specific foods. Nonetheless, the elevated EpiPen rates and declaration ratios in the early primary stage (declaration ratio: approximately 25% compared to 18%–21% across all other stages) suggest that the entitlement is influencing declaration behavior specifically in these grades.

Trends by SES reveal a steep and consistent socioeconomic gradient in both sensitivity and EpiPen rates, increasing steadily from the lowest to the highest SES clusters. The gap between the lowest and highest SES clusters widened over the study period for both measures; for sensitivity rates specifically it rose from 2.9 to 4.4 percentage points. Declaration ratios showed no consistent SES gradient, with median rates broadly similar across clusters. The SES gap in sensitivity and EpiPen rates is consistent with international findings on differential access to specialist diagnosis and allergy care (Coombs et al., 2011), which is documented in Israel as well: public allergy services are limited, with some hospitals and health funds providing minimal or no allergy care, leaving families who cannot afford a costly private alternative without comparable access (Mayzel, 2025). Declaration rate differences may therefore reflect gaps in access to health services rather than true differences in allergy prevalence across SES levels.

Examining SES trends by educational stage, the higher EpiPen rates in early primary were concentrated in higher-SES localities (1.09% in 2022/23, rising to 1.27% in 2024/25), with the lowest SES localities showing negligible differences in rates across educational stages. This points to a policy paradox: while the medical assistant entitlement is formally universal, its effects appear to operate predominantly in higher-SES communities, raising questions about its implementation. Even when children from lower-SES localities do obtain a diagnosis and qualify, they may still go without protection: approved families face a shortage of available assistants, and unlike higher-SES families, they cannot fill the gap privately.

The patterns of inequality found by SES extend to educational stream: EpiPen rates were highest in the Hebrew State and State-religious streams across all educational stages, while all other streams remained low and largely flat throughout. The higher EpiPen rates in early primary were also only evident in these two streams. Similarly, the Knesset Research and Information Center reported medical assistant entitlements are heavily concentrated in Jewish localities, with non-Jewish localities accounting for only 2.8% to 4.8% of all approvals (Mayzel, 2025). The differences between educational streams likely reflect a combination of structural barriers to specialist diagnosis and variation in compliance with the health declaration form. While the annual health declaration is mandatory, compliance is not systematically enforced; parents of children with known allergies are nonetheless more motivated to complete the

form, and therefore declaration rates should provide a reasonable indication of allergy prevalence in the student population. However, variation in compliance across SES levels and educational streams may further influence the patterns observed. Taken together, the SES and educational stream findings point to the same conclusion: a policy that is formally universal is in practice benefiting almost exclusively students in higher-SES Jewish state-sector schools.

As the medical assistant program continues to expand, this inequitable distribution means that a growing and increasingly costly public commitment is being channeled disproportionately into higher-SES schools. At the same time, Israel is, to the best of available knowledge, the only country in the world to impose blanket school-wide bans on multiple allergens, a policy approach that international and local medical bodies recommend against (Elizur et al., 2026; Muraro et al., 2014; Sicherer et al., 2010; Waserman et al., 2021). While the policy emerged in response to rising food sensitivity rates and structural features of the Israeli school system, including the absence of school nurses and the lack of dedicated eating spaces, the current findings, combined with the absence of an established evidence base for these policies, suggest reassessment is warranted.

Limitations

Declaration data are based on parental reports and compliance with the health declaration form is not systematically enforced, meaning that true allergy prevalence in the school population may differ from declared rates (Elizur et al., 2026). The steep SES and educational stream gradients observed likely reflect a combination of genuine epidemiological differences, differential access to specialist diagnosis, and variation in form completion rates; these factors cannot be disentangled with the available data. In addition, simultaneous analysis of SES and population group was not possible given the structure of the data provided. Finally, as declaration data at the educational stream level were available only for EpiPen carriage and not for sensitivity declarations, the full picture of group-level disparities remains incomplete.

Policy options: Structural constraints and the case for reform

Israel's policies did not emerge in a vacuum. They reflect genuine structural constraints: the absence of school nurses since the 1990s, no cafeterias or dedicated eating areas, and a growing allergy burden coinciding with a documented shortage of allergy and immunology specialists (Elizur et al., 2026). The specialist shortage in particular reduces access to accurate diagnosis and limits the specialist follow-up that represents the most evidence-based intervention for reducing severe reactions. It is also the same barrier that shapes who can obtain the medical assistant entitlement. The findings of the present study suggest that the current policy framework requires reassessment on three dimensions.

Restoring school nurses

First, the medical assistant model is generating growing and inequitably distributed budgetary commitments without an established evidence base. The program has grown 20-fold in 15 years—from 511 entitled students in 2010/11 to 10,312 in 2024/25—while the student population grew only 1.3-fold over the same period (Moshe, 2026). The total budget allocated to medical assistants for food allergy students in 2024/25 reached NIS 523 million, a substantial and growing public commitment concentrated overwhelmingly in higher-SES and Jewish state-sector communities as our findings demonstrate. Replacing this model through the restoration of on-site school nursing would provide more consistent, professionally grounded, and equitable coverage.

A recent cost assessment study found that employing a school nurse in every primary and middle school would cost approximately NIS 462–488 million annually, suggesting that the transition is financially viable without requiring significant additional public investment (Moshe, 2026). Both the Ministry of Education and the Israel Association of Allergy and Clinical Immunology support this model, and a pilot is currently being planned in several primary schools (Elizur et al., 2026; Moshe, 2026). A key challenge to this plan is Israel's nursing shortage, particularly in the periphery; expanding school nursing would require training and recruiting additional nurses as part of any transition plan. Unlike the medical assistant model, school nurses would extend coverage across all educational stages, including adolescence, the population at highest clinical

risk of severe anaphylaxis. Beyond allergy management, school nurses would address a broader gap in school health infrastructure: since nurses left the school system, Israel has faced growing challenges in vaccination compliance, mental health support, and health monitoring among school-age children. School nurses would therefore provide wide-ranging public health benefits as well as ensure a safe learning environment for students with food allergies.

Age-differentiated policy

Second, the current food ban policy applies uniformly across all educational stages, yet a blanket approach is neither developmentally appropriate nor educationally sound. As children grow older, the education system should foster increasing autonomy and self-management, the ultimate goal being that students can navigate the world safely and independently. This is particularly pressing given that anaphylaxis mortality risk is clinically highest among adolescents (Baseggio Conrado et al., 2021; Pouessel et al., 2018), whom the current policy nonetheless leaves exposed. Returning school nurses would answer this.

Preschool presents distinct challenges. Young children cannot yet take full responsibility for their allergies, but placing a nurse in every preschool is not practical, as each preschool operates in its own separate building. In the absence of research evidence supporting the effectiveness of the aide model, a different approach could be adopted in preschool: subsidizing the mid-morning snack so that it does not contain the declared allergen in any preschool attended by a child with a food allergy. This option would reduce the risk of exposure while taking into account the children's developmental stage, and would provide a more practical and equitable alternative to assigning a dedicated medical aide.

Any policy reform must therefore be age-differentiated to reflect the medical, developmental, and educational realities of each stage.

Equal access to basic safety for all

Third, the current school policy framework places disproportionate emphasis on environmental restriction through food bans that are becoming increasingly pervasive yet difficult to enforce, and medical assistants who lack training and are disproportionately placed in advantaged schools. Meanwhile, basic safety measures such as ensuring valid EpiPens in every school remain inconsistently implemented, and closing these gaps between schools should be a priority.

A rebalanced policy should prioritize equal access, age-differentiated approaches, and the restoration of on-site school nursing as part of a broader school health infrastructure. Beyond safety, the current policy also sends an implicit message to students that food allergy requires constant external management rather than self-regulation, which runs counter to the developmental goals of education.

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