

Food Allergy Prevalence, Severity, and Disparities

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Learning Objectives

1. Describe the prevalence and severity of pediatric and adult food allergy in the U.S.
1. Characterize the various barriers to managing food allergies, including access to care, economic impact, and food insecurity.
1. Offer recommendations and resources for addressing the burden of food allergy.

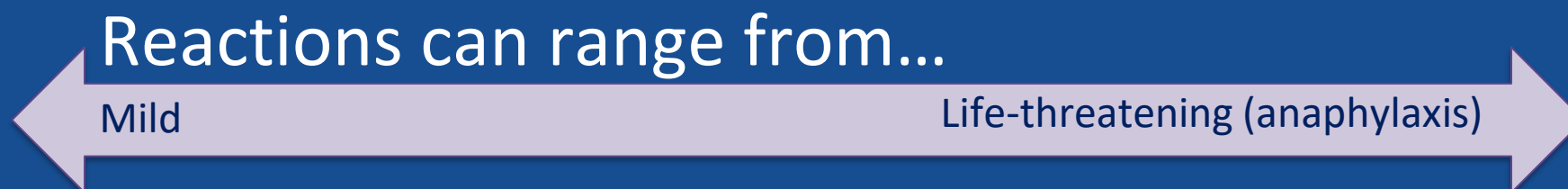


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The Public Health Impact of Food Allergy in the U.S.

THE FOOD ALLERGY EPIDEMIC



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OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

The Public Health Impact of Parent-Reported Childhood Food Allergies in the United States

Ruchi S. Gupta, MD, MPH,^{a,b,c,d} Christopher M. Warren, BA,^e Bridget M. Smith, PhD,^{c,f} Jesse A. Blumenstock, BS,^c
Jialing Jiang, BA,^c Matthew M. Davis, MD, MAPP,^{a,b,c,d,g} Kari C. Nadeau, MD, PhD^h

Gupta RS, Warren CM, Smith BM, Blumenstock JA, Jiang J, Davis MM, et al. The Public Health Impact of Parent-Reported Childhood Food Allergies in the United States. *Pediatrics*. 2018;142(6):e20181235.

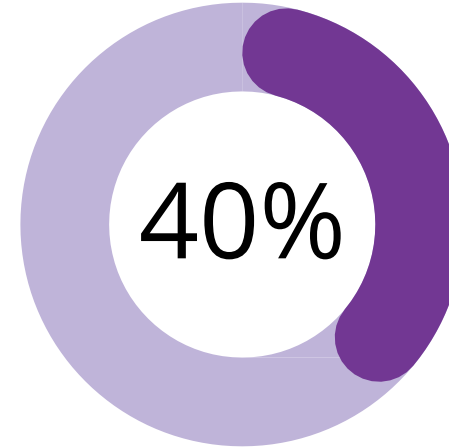
8% of US children have food allergies? Luckily very little of what they eat is technically food...

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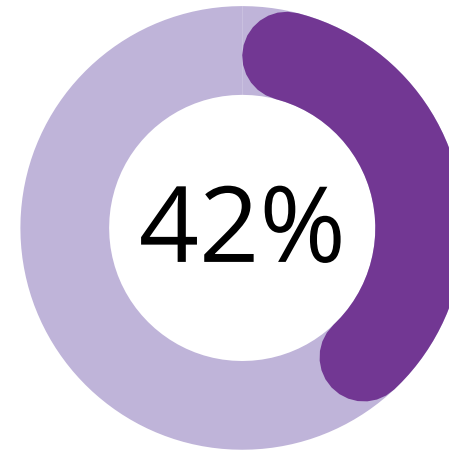
The Prevalence, Severity, and Distribution of Childhood Food Allergy in the United States



Childhood Food Allergy Prevalence in the U.S.



are allergic to multiple foods

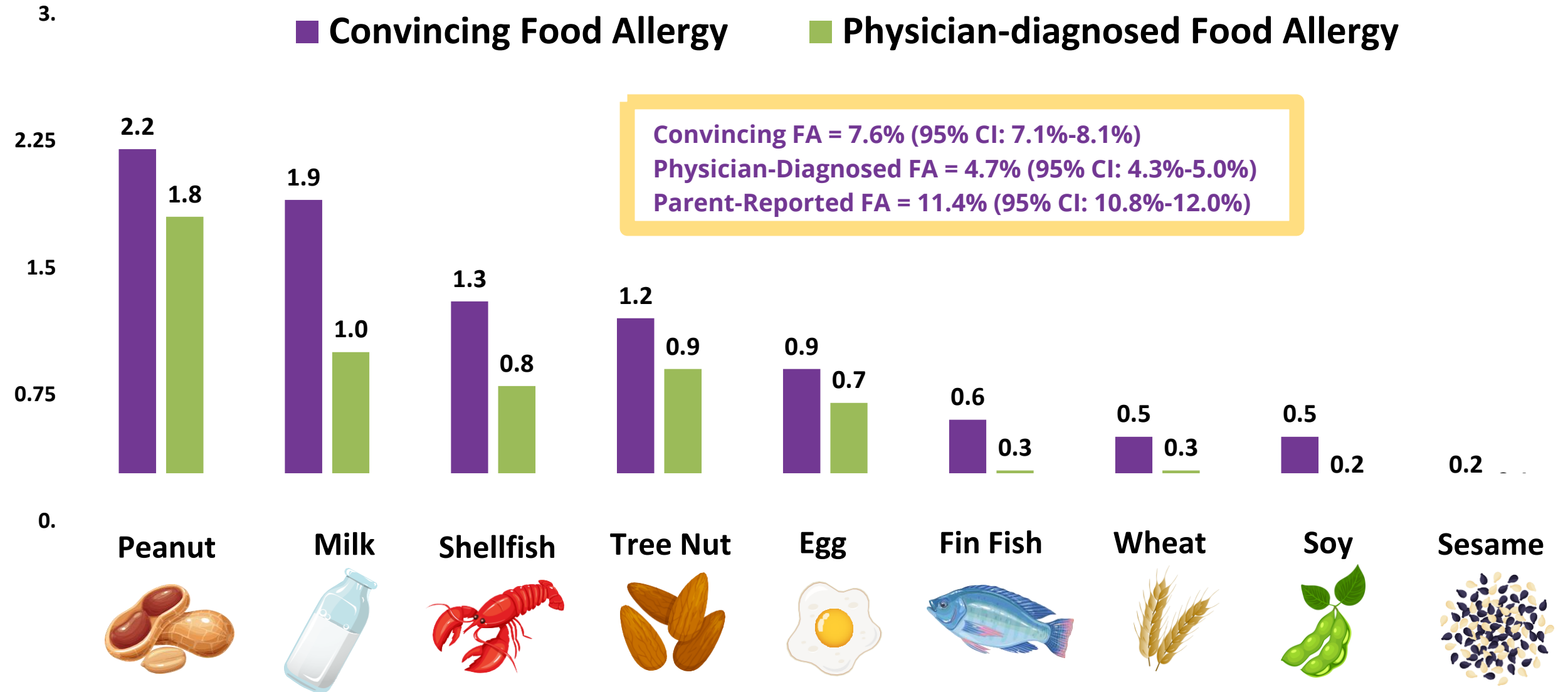


have experienced a severe reaction

Childhood Food Allergy Prevalence in the U.S.

■ Convincing Food Allergy

■ Physician-diagnosed Food Allergy



Food Allergen Prevalence by Age



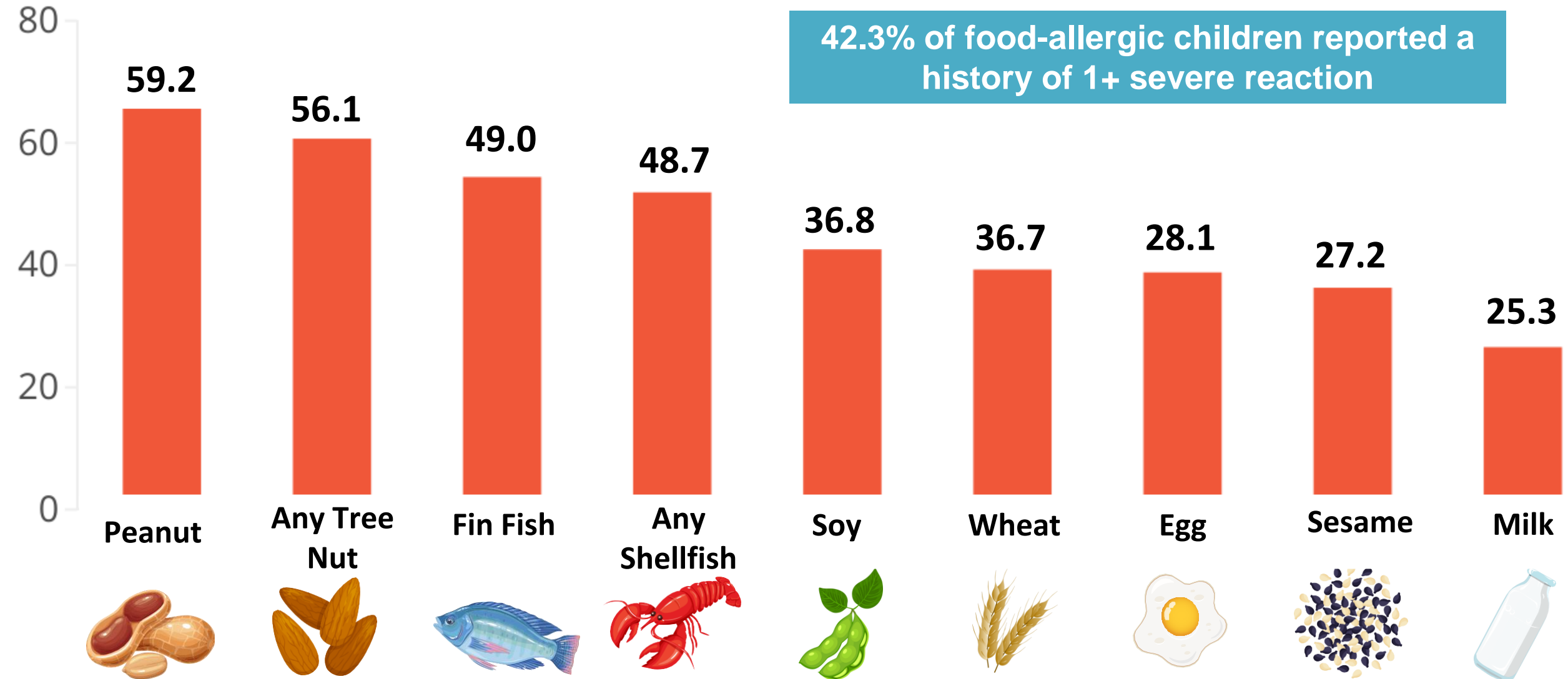
	Peanut	Tree Nut	Milk	Shellfish	Egg	Fin Fish	Wheat	Soy	Sesame
<1 Year	20.2%	9.0%	53.0%	7.1%	13.5%	2.6%	14.9%	15.4%	4.6%
1 Y	24.6%	8.0%	37.8%	5.1%	22.8%	6.4%	6.0%	16.6%	4.9%
2 Y	24.5%	10.9%	43.5%	11.5%	14.1%	6.0%	9.9%	8.6%	2.3%
3-5 Y	25.1%	15.9%	33.6%	13.0%	15.0%	6.2%	6.6%	6.9%	2.7%
6-10 Y	32.8%	17.6%	24.4%	18.4%	10.8%	7.8%	6.4%	6.5%	3.3%
11-13 Y	30.5%	21.3%	14.9%	20.2%	12.8%	7.1%	6.2%	3.6%	1.8%
>14 Y	29.5%	13.3%	16.0%	21.3%	6.6%	7.9%	5.4%	3.0%	2.1%

CoFAR Grading Scale for Systemic Allergic Reactions in Food Allergy

- Grade 1** Generalized urticaria, localized angioedema, rhinitis, and abdominal pain
- Grade 2** Mild, multisystem reactions
- Grade 3** Moderate reactions with lower respiratory tract symptoms responsive to therapy
- Grade 4** Severe reactions requiring multiple doses of epinephrine or mechanical ventilation
- Grade 5** Life-threatening reactions resulting in death

Childhood Food Allergy Severity

42.3% of food-allergic children reported a history of 1+ severe reaction



Patterns of Convincing Multi-Food Allergy Among US

	Peanut	Tree Nut	Sesame	Milk	Egg	Fin Fish	Shellfish	Soy	Wheat
Peanut	100	61	55	15	29	38	25	33	22
Tree Nut	33	100	44	9	18	24	14	24	18
Sesame	5	8	100	3	6	9	5	11	13
Milk	13	15	23	100	35	15	11	37	43
Egg	12	13	26	17	100	20	11	25	21
Fin Fish	9	11	23	4	12	100	24	14	12
Shellfish	15	15	31	7	16	57	100	20	21
Soy	7	10	26	9	13	12	7	100	26
Wheat	5	8	31	11	12	11	8	27	100

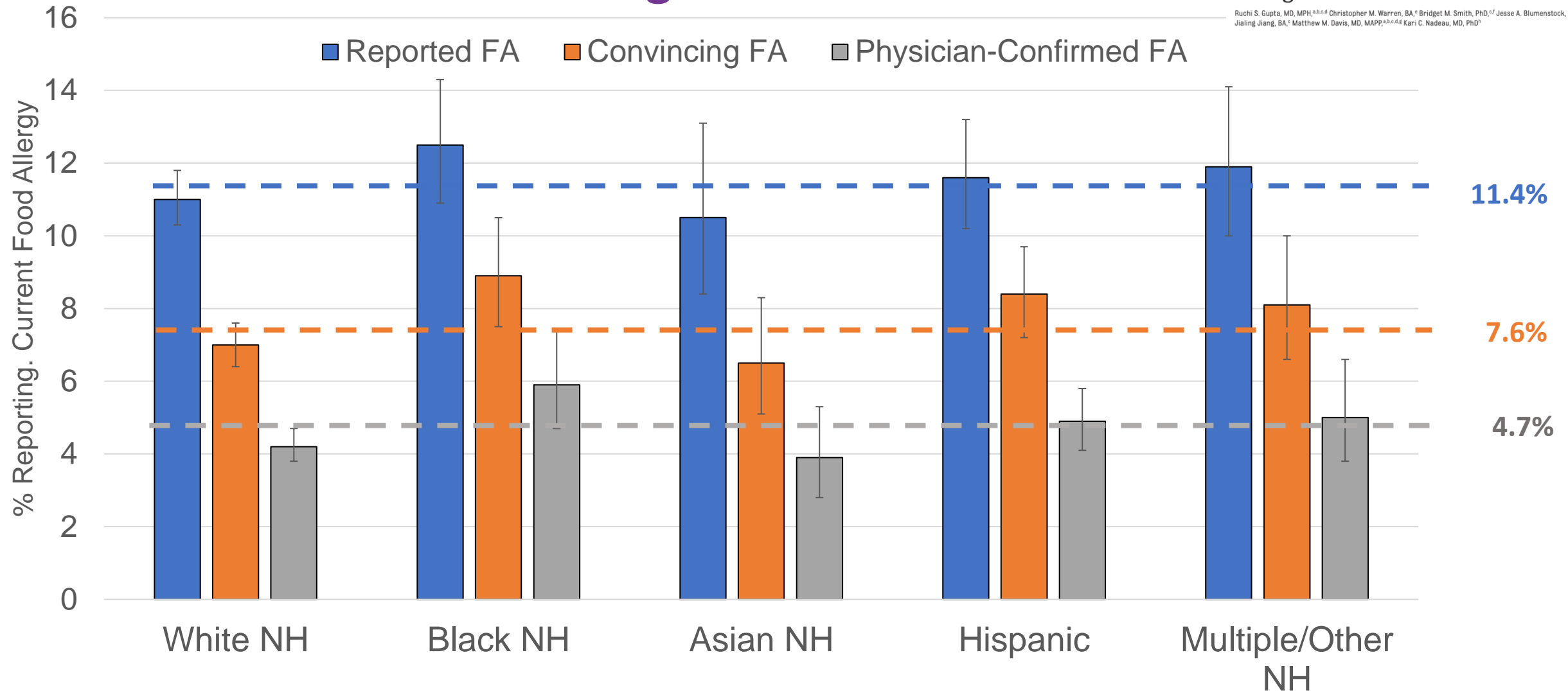
(% of children with convincing column allergy who are also allergic to the row allergen)

Racial and Ethnic Differences in Current Food Allergy Prevalence among US Children

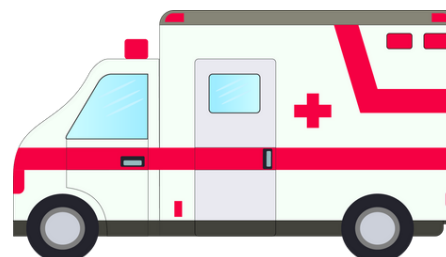
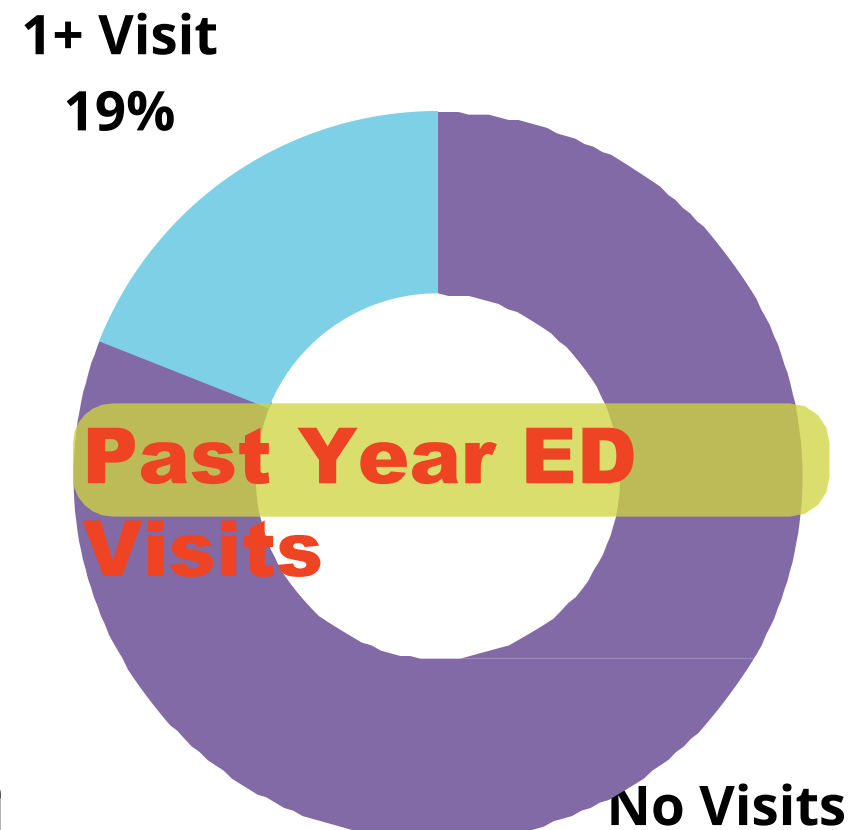
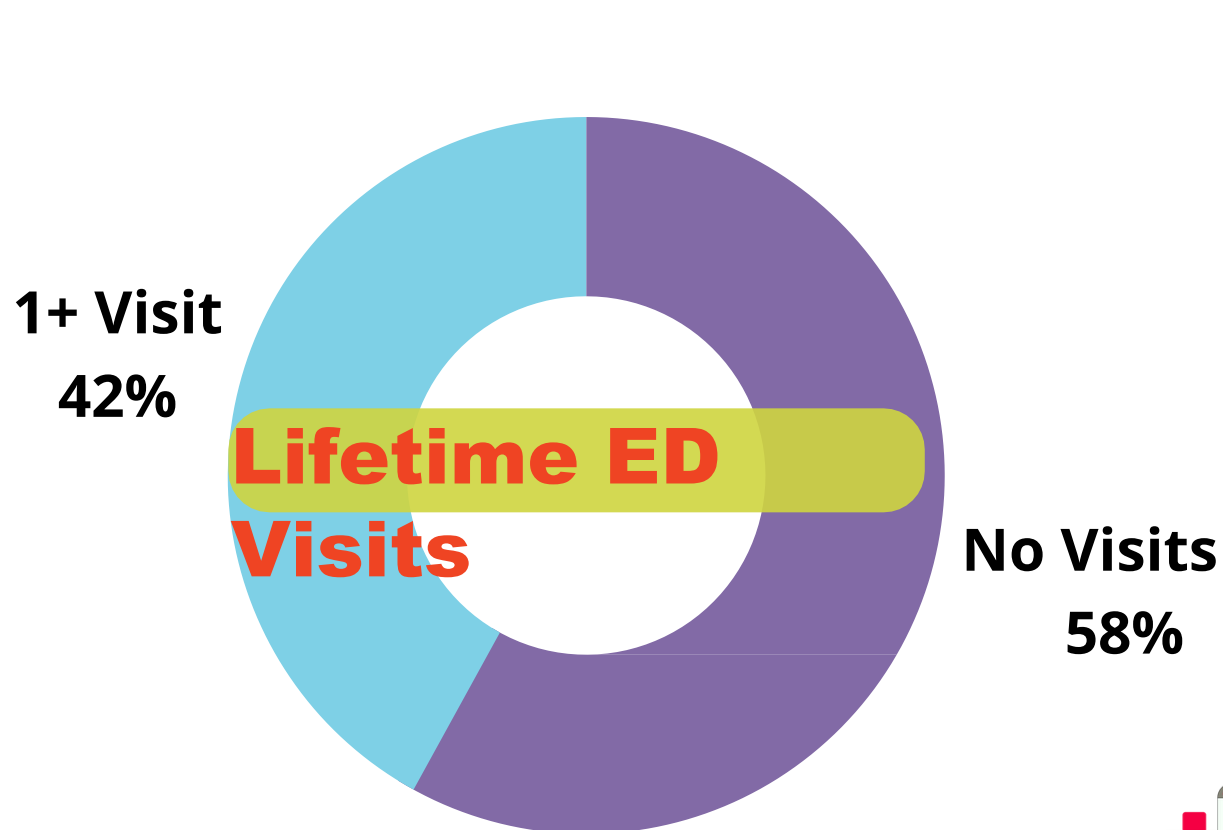
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The Public Health Impact of
Parent-Reported Childhood Food
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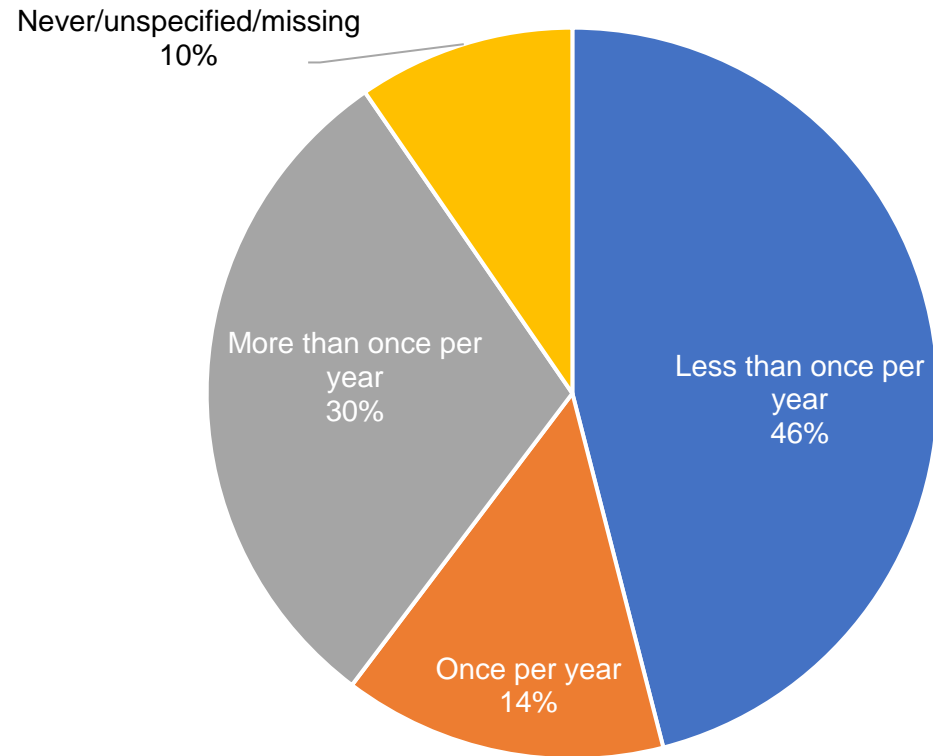


Pediatric FA Emergency Department Visits

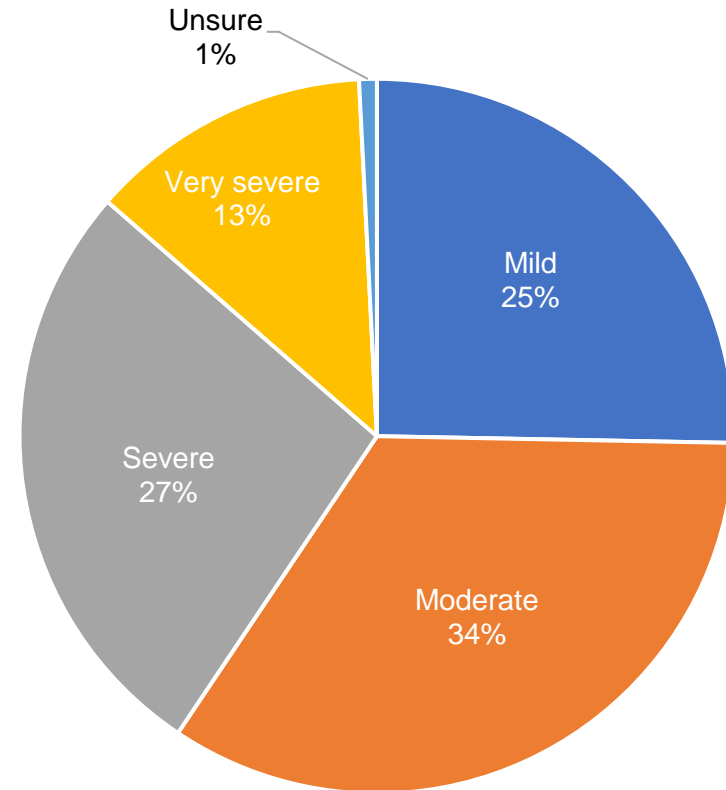


Parent-Reported Reaction History

National Patient Registry



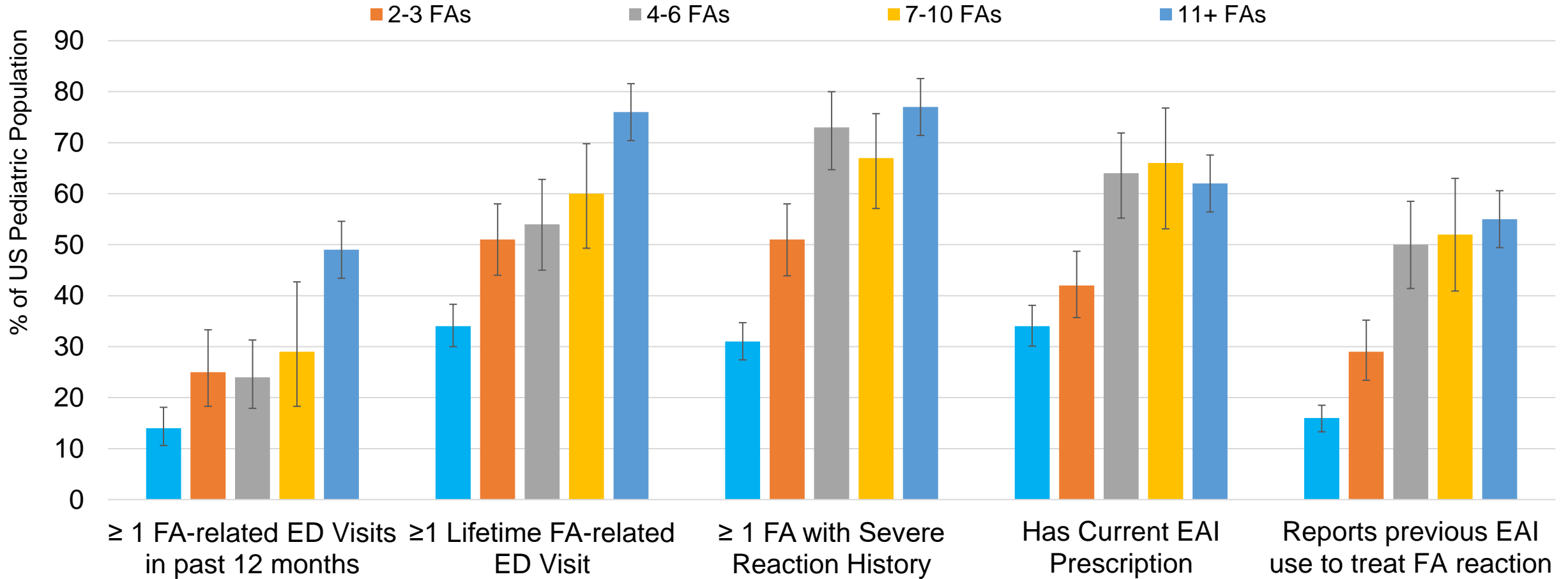
Average Number of Reactions



Perceived Severity of Most Recent Reaction

Pediatric Clinical Outcomes

By Number of Current Convincing Food Allergies



Pediatric Atopic Comorbidities

Rates of physician-diagnosed atopic conditions were **significantly higher among children with convincing FA** compared with other children

Physician Diagnosed Comorbid Conditions	All Children	Children with FA	P-Value
Asthma	12.2 (11.4–13.0)	32.6 (29.5–35.9)*	<.001*
Atopic Dermatitis	5.9 (5.3–6.5)*	14.9 (12.5–17.7)*	<.001*
Eosinophilic Esophagitis (EoE)	0.2 (0.10-0.2)*	0.7 (0.4–1.1)*	<.001*
Allergic Rhinitis	12.8 (12.0–13.6)*	30.4 (27.6–33.4)*	<.001*
Other Chronic Condition	4.2 (3.7–4.7)*	10.1 (8.2–12.3)*	<.001*



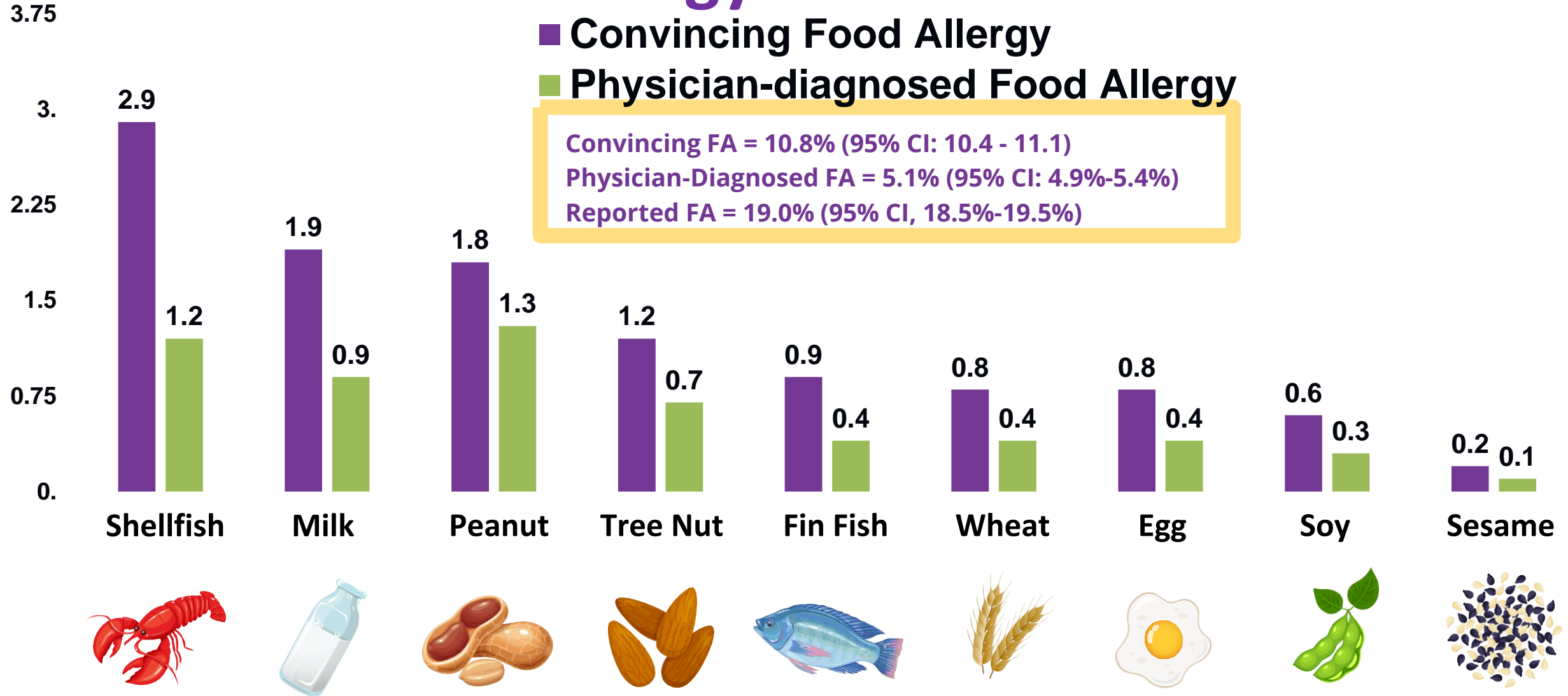
Original Investigation | Allergy

Prevalence and Severity of Food Allergies Among US Adults

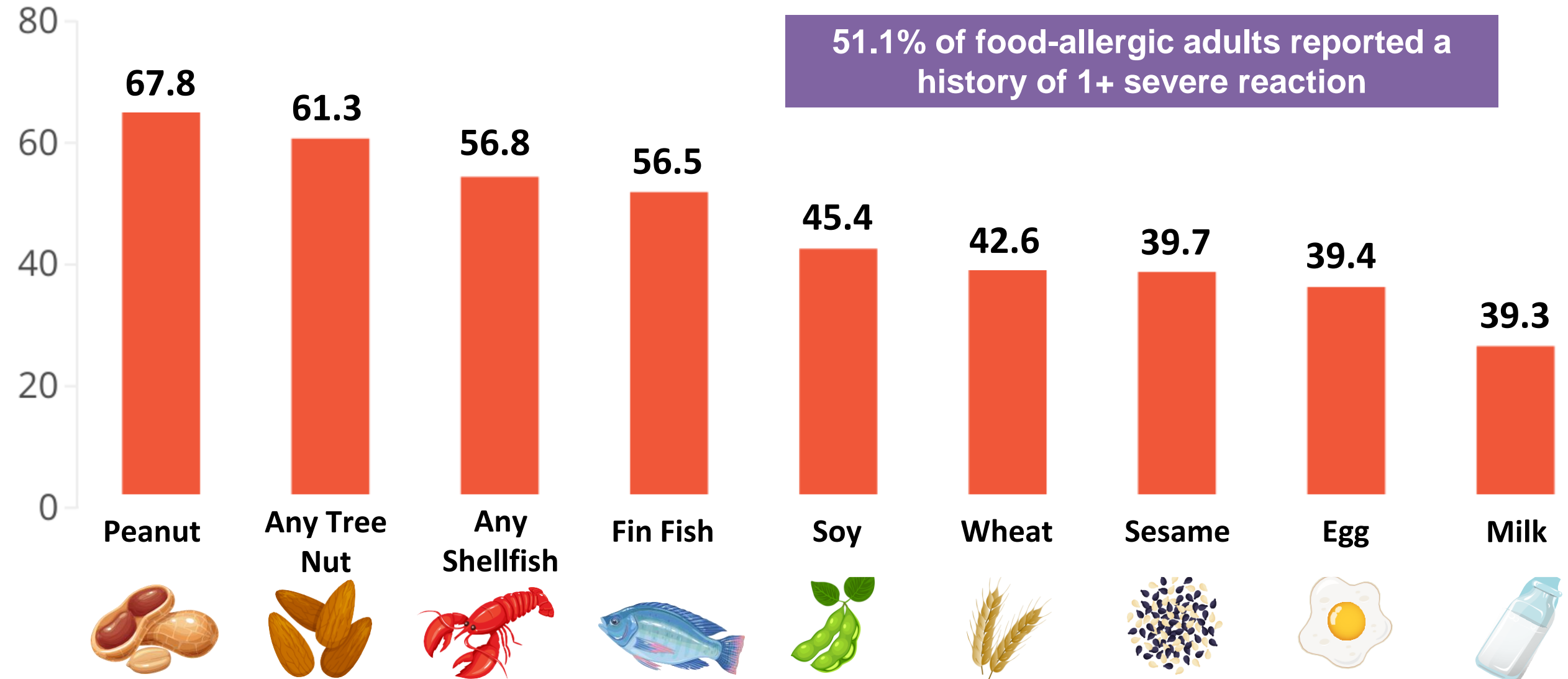
Ruchi S. Gupta, MD, MPH; Christopher M. Warren, BA; Bridget M. Smith, PhD; Jialing Jiang, BA; Jesse A. Blumenstock, BS; Matthew M. Davis, MD, MAPP;
Robert P. Schleimer, PhD; Kari C. Nadeau, MD, PhD

Gupta RS, Warren CM, Smith BM, Jiang J, Blumenstock JA, Davis MM, et al. Prevalence and Severity of Food Allergies Among US Adults. *JAMA Network Open*. 2019;2(1):e185630-e185630.

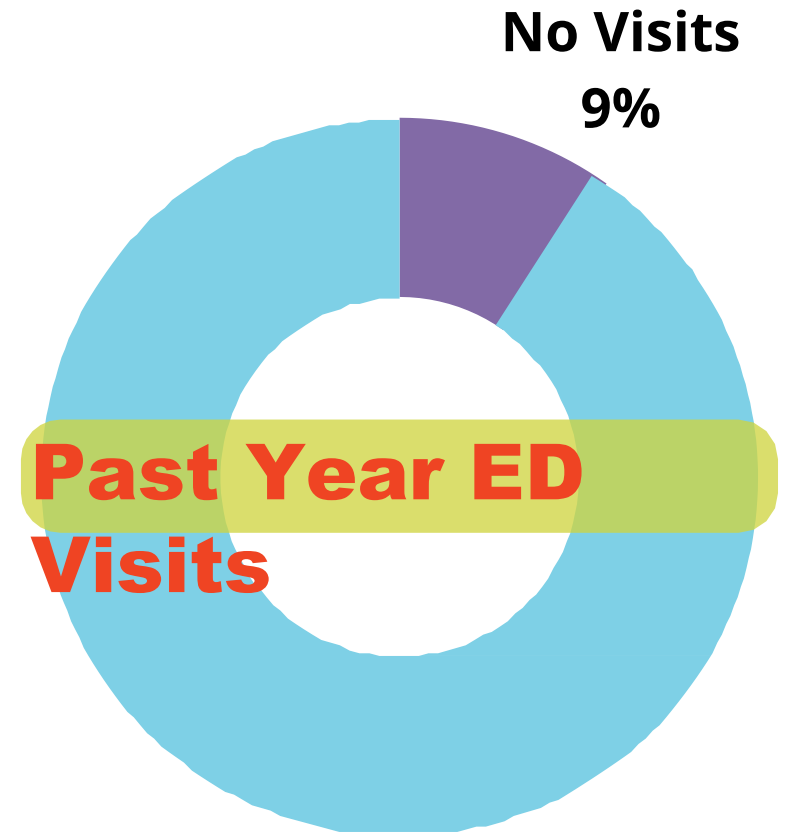
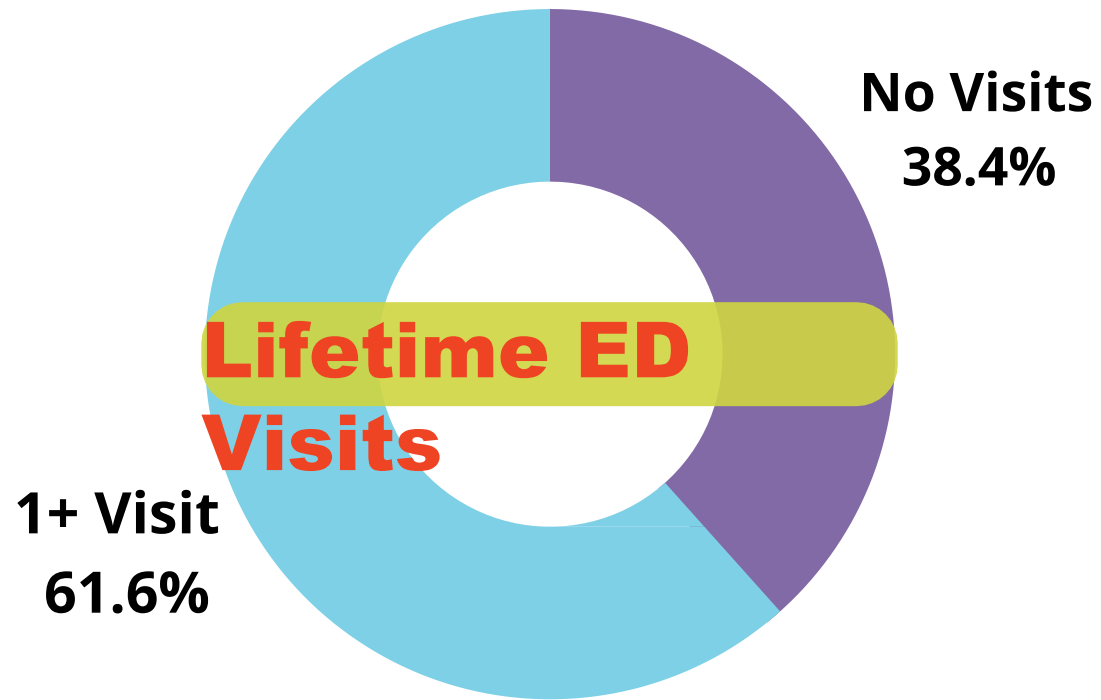
Adult Food Allergy Prevalence in the U.S.



Adult Food Allergy Severity

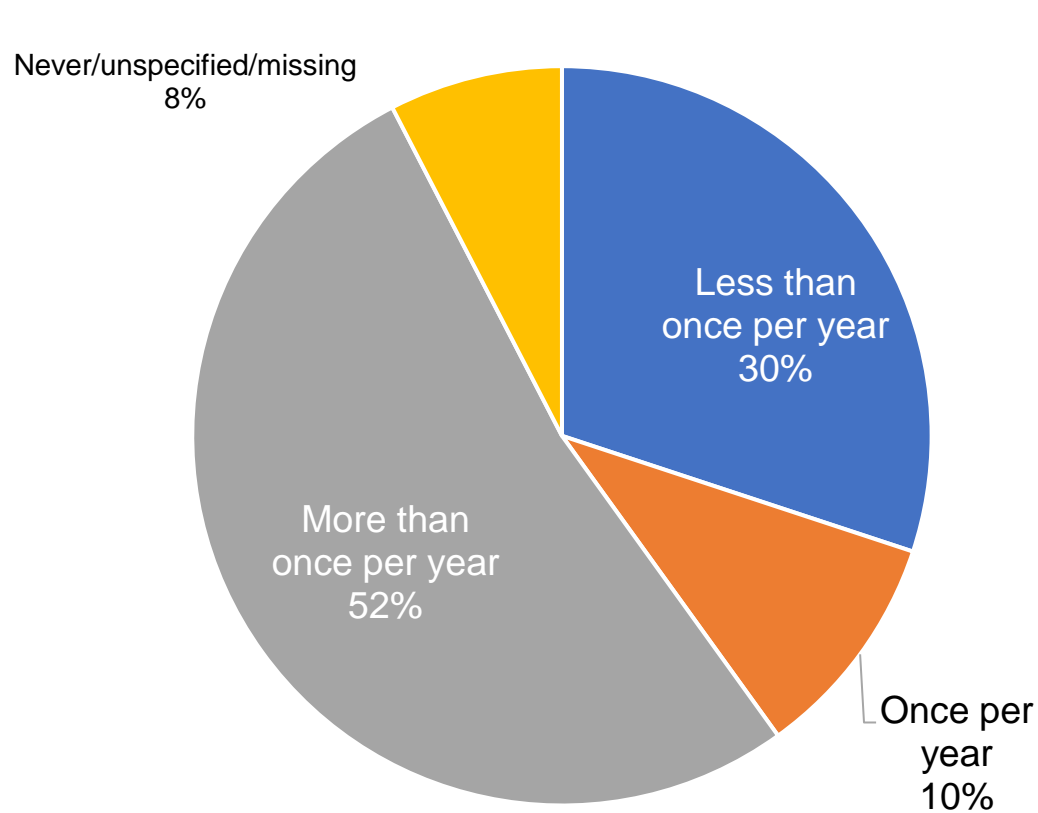


Adult FA Emergency Department Visits

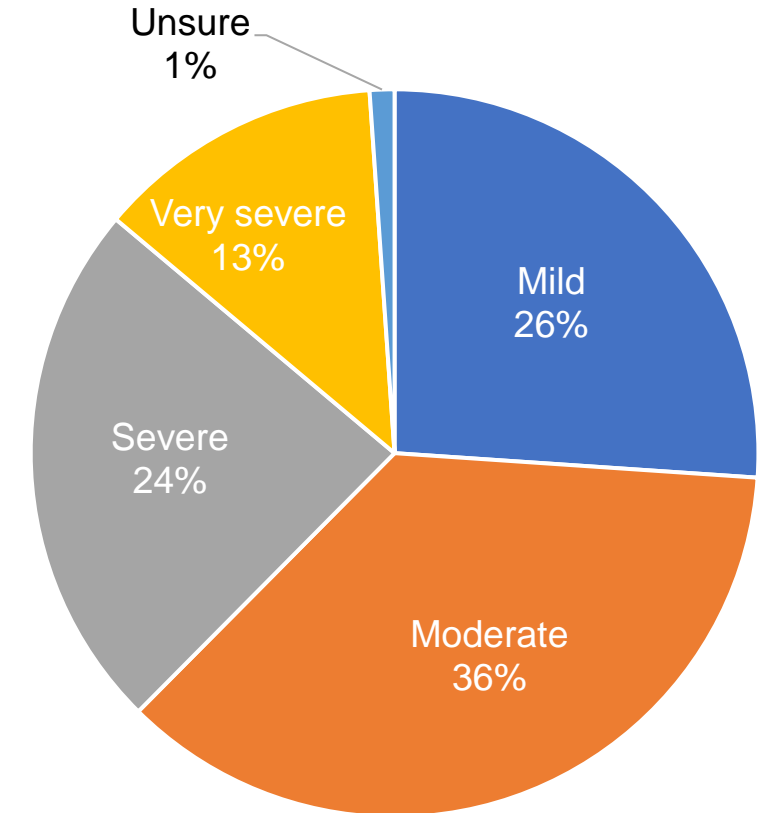


Adult Self-Reported Reaction History

FARE National Patient Registry



Average Number of Reactions



Perceived Severity of Most Recent Reaction

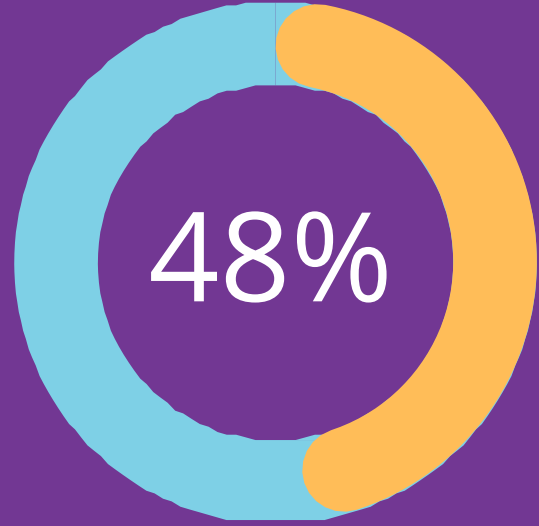
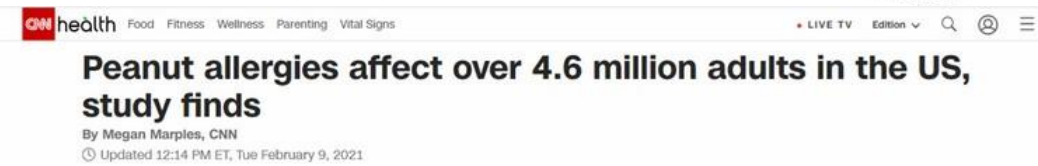
Food Allergies in Adults

More than 10% of U.S. adults – or more than 26 million people – have a history of food allergy.



More adults developing food allergies but many go undiagnosed

More adults than children have food allergies and a new study suggests there's more to learn.



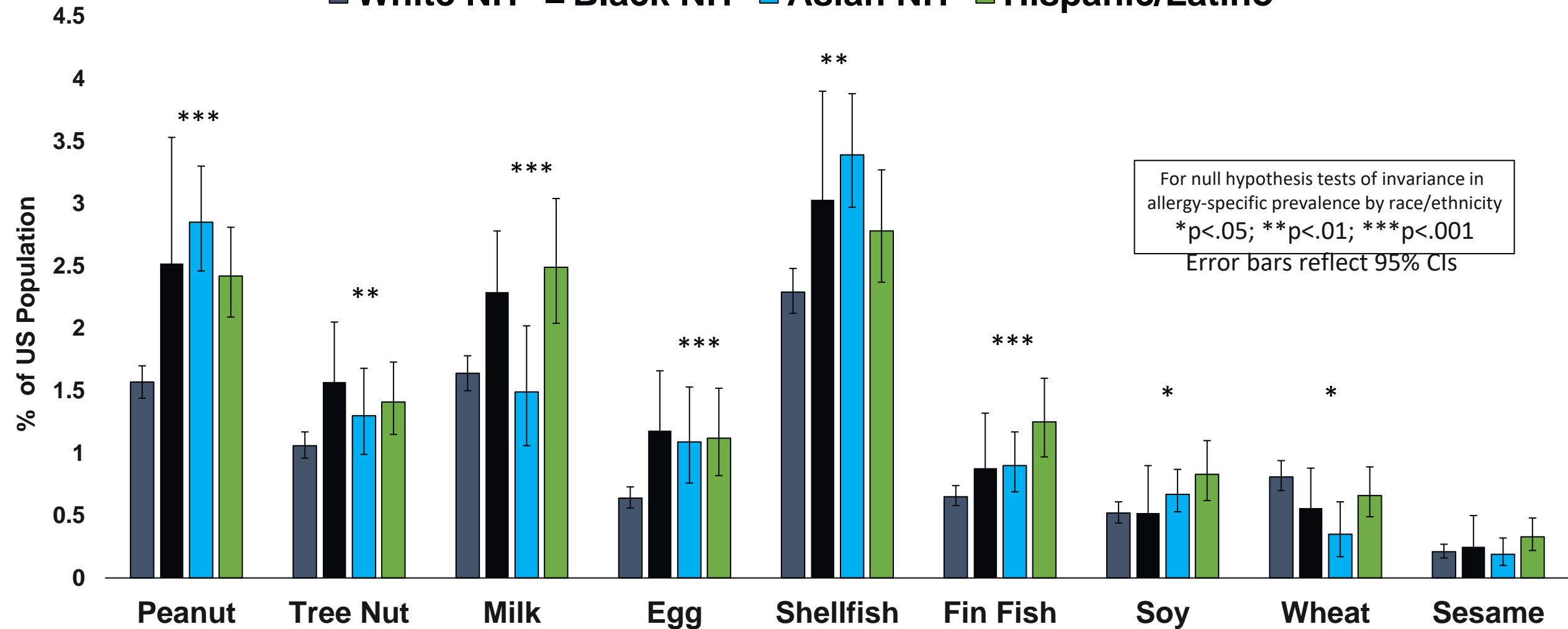
of food allergic-adults reported an adult onset food allergy



Nearly 1 in 5 Americans report they have had a severe reaction to food

Top Allergens by Race/Ethnicity

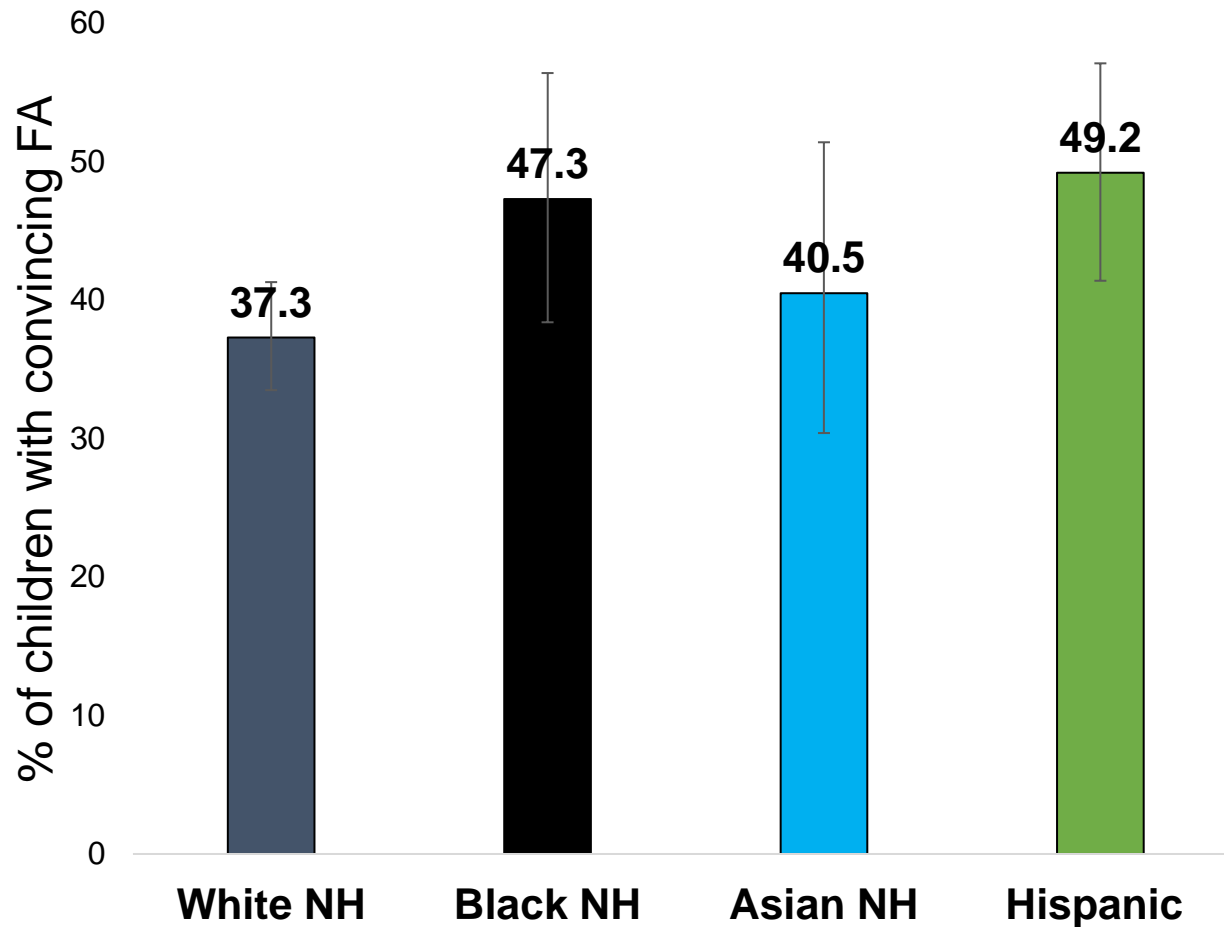
■ White NH ■ Black NH ■ Asian NH ■ Hispanic/Latino



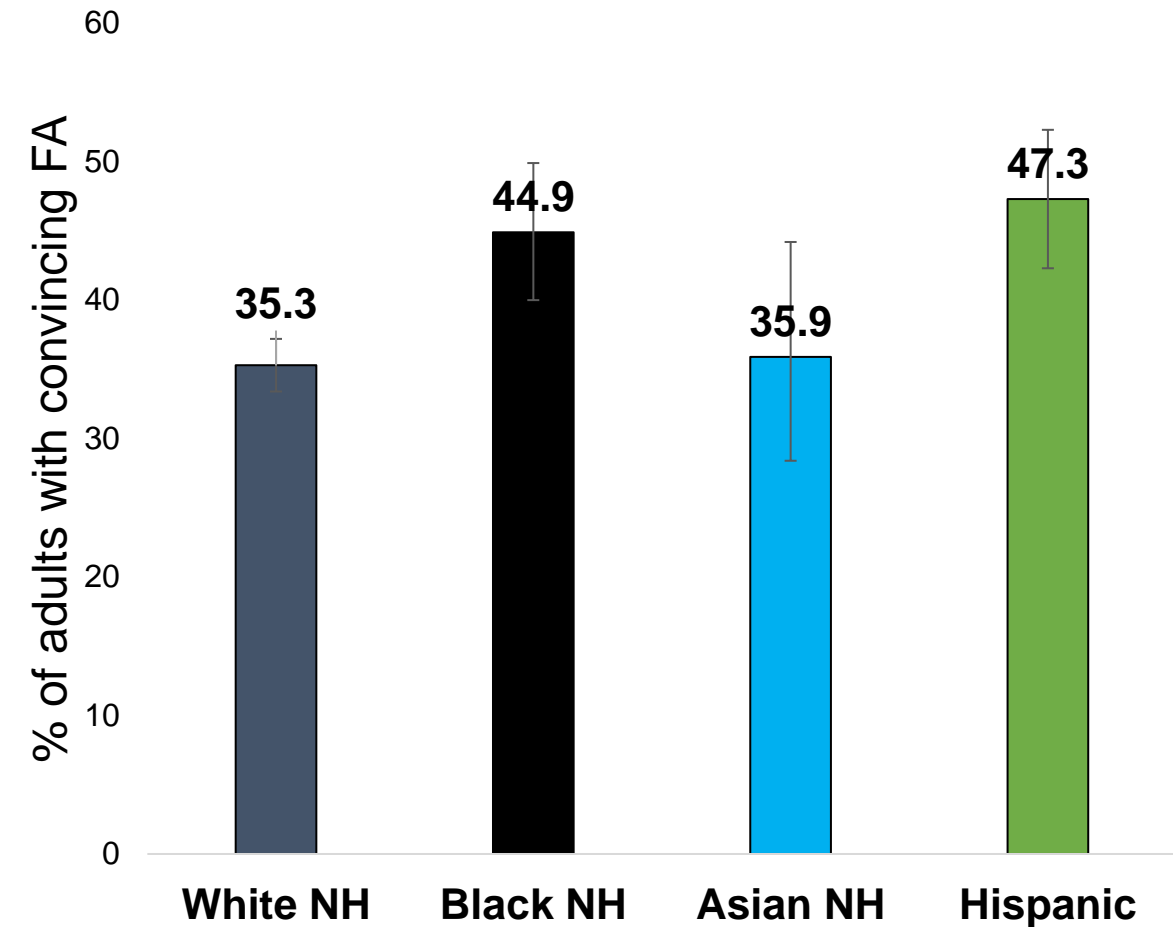
Peanut, Milk, Shellfish, Finfish allergy are significantly higher among minority populations compared to White Americans

Lifetime FA-related Emergency Department Visits Higher in Black and Hispanic Populations

US Children



US Adults



Retrospective Analysis Uncovers Pronounced Racial Differences in Food Allergy Phenotype and Health Care Utilization

Original Article

Racial Differences in Food Allergy Phenotype and Health Care Utilization among US Children



Mahboobeh Mahdavinia, MD, PhD^a, Susan R. Fox, PA^a, Bridget M. Smith, PhD^{b,c,d}, Christine James, MD^a, Erica L. Palmisano, MD^a, Aisha Mohammed, MD^a, Zeeshan Zahid, MD^a, Amal H. Assa'ad, MD^e, Mary C. Tobin, MD^a, and Ruchi S. Gupta, MD, MPH^{b,d} *Chicago and Hines, Ill; and Cincinnati, Ohio*

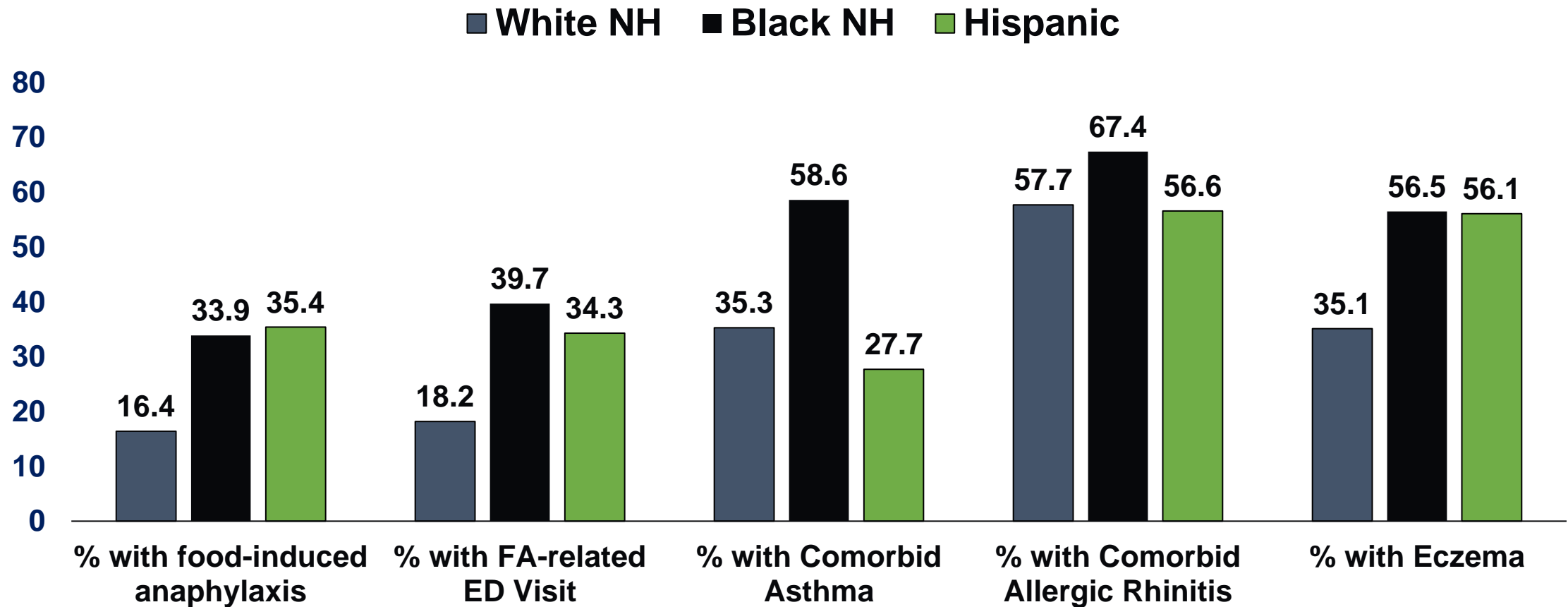
What is already known about this topic? There is a paucity of data in the epidemiology of food allergy (FA) as it relates to race and/or ethnicity. The limited existing data show that African American children are at an increased risk for FA and its associated morbidities, and there are no data on Hispanic children with FA.

What does this article add to our knowledge? We found that African American (AA) and Hispanic children had different food allergen profiles, higher rates of associated atopic conditions, and increased rates of FA-associated anaphylaxis and emergency department visits than white children.

How does this study impact current management guidelines? The higher rates of asthma and anaphylaxis among minority children are concerning, especially when considered in the context of increased anaphylaxis in AA children. These findings highlight the need for culturally sensitive educational programs to improve FA outcomes in these children.

- Multi-center, retrospective cohort study of children aged 0-17 years with FA seen in allergy/immunology clinics at 2 US urban tertiary care centers
- N=817: 35% Black, 12% Hispanic, 53% non-Hispanic white

Racial Differences in Food Allergy Phenotype and Health Care Utilization



FORWARD



- Original 5-year, multi-site, NIH/NIAID funded R01 study (R01 ID #AI130348) to examine food allergies in White, Black, and Hispanic/Latinx populations
- Clinical EMR data extraction, quarterly surveys, biospecimen collection
- **Goal:** Understand differences in food allergy phenotypes/endotypes, diagnosis, management, quality of life by race/ethnicity in order to improve equitable care





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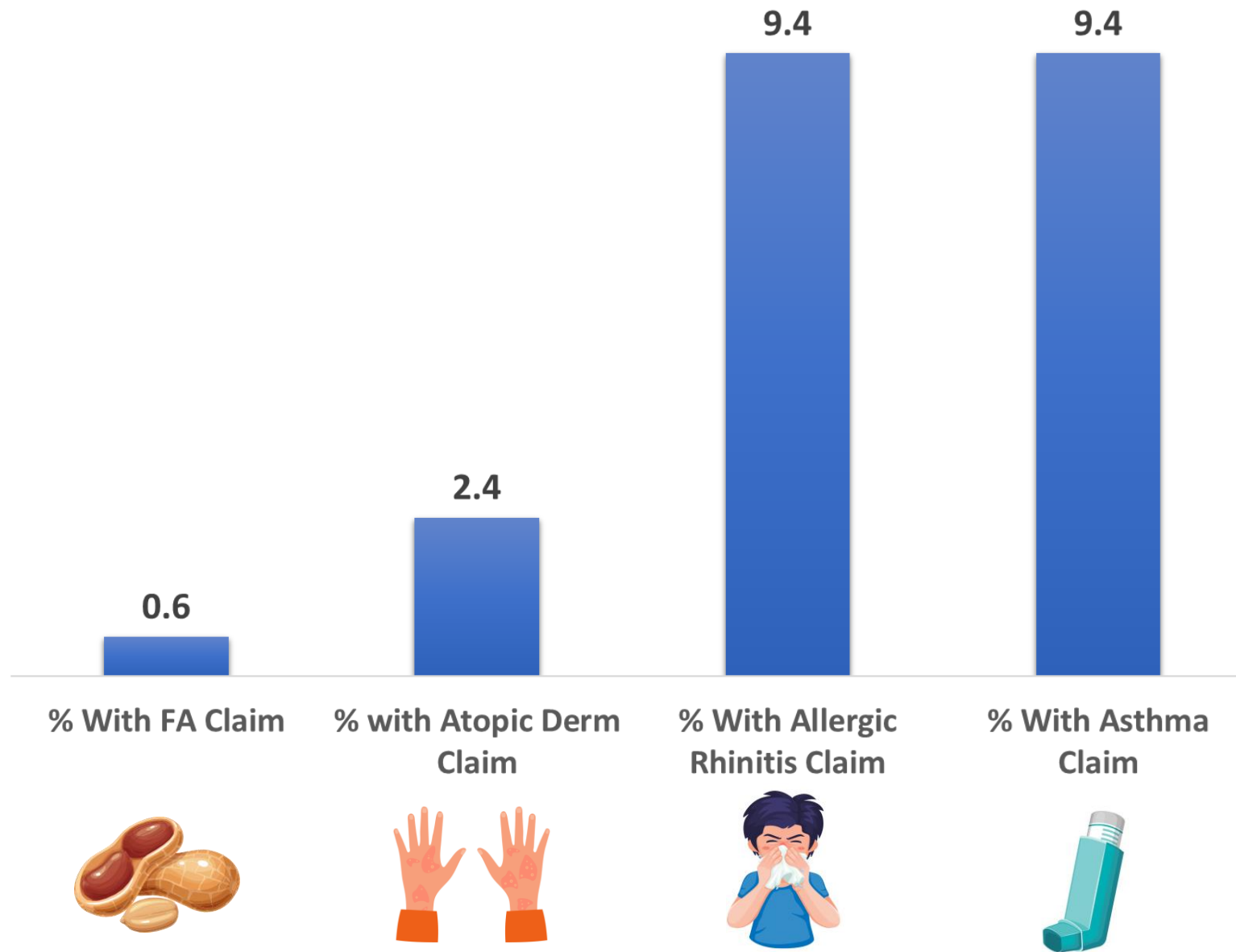
Access to Care

Diagnosis

Prevalence of FA diagnosis among Medicaid-enrolled US children is substantially lower (0.6%) compared to previous national estimates using parent surveys (7.6%) and reports of physician confirmation of food allergy (4.7%)

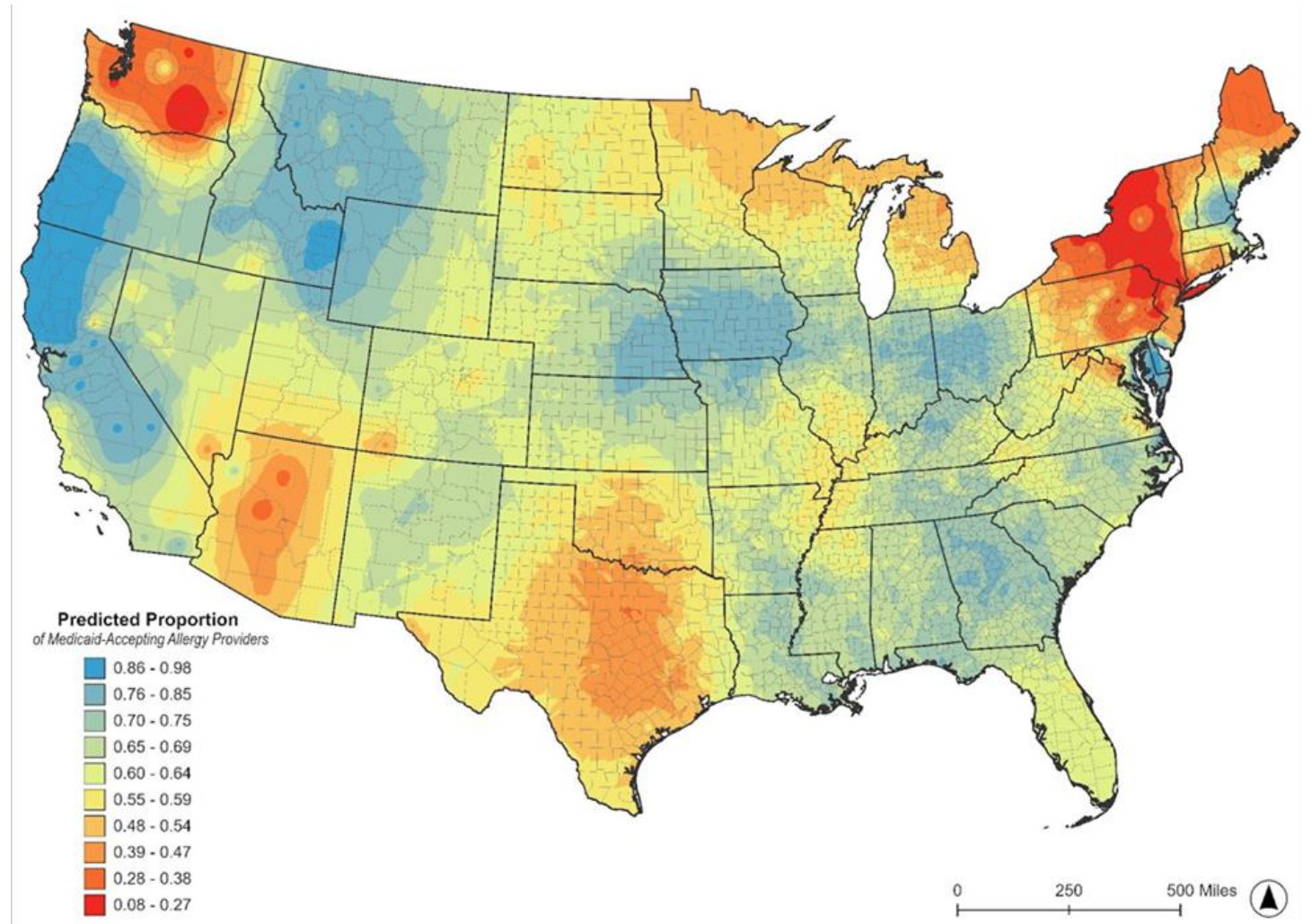


Atopic Condition Claims Among Medicaid Enrolled Children



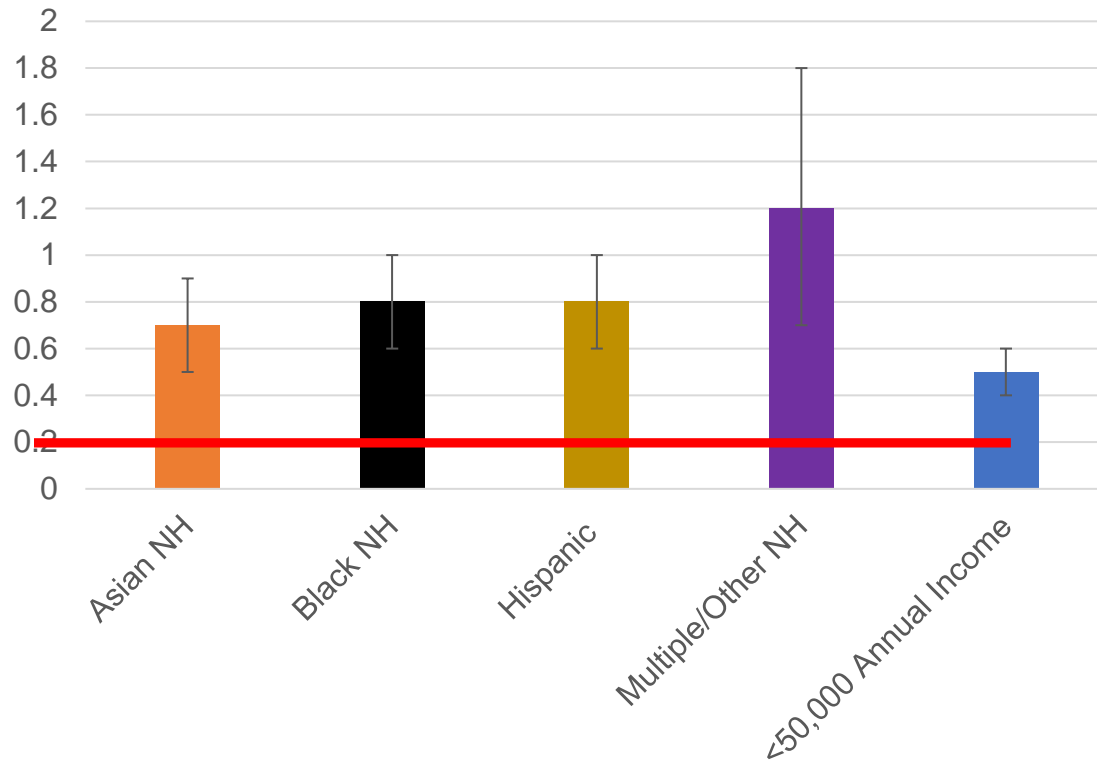
Medicaid-Accepting Allergists

- Only 55.5% of allergists accept Medicaid nationwide

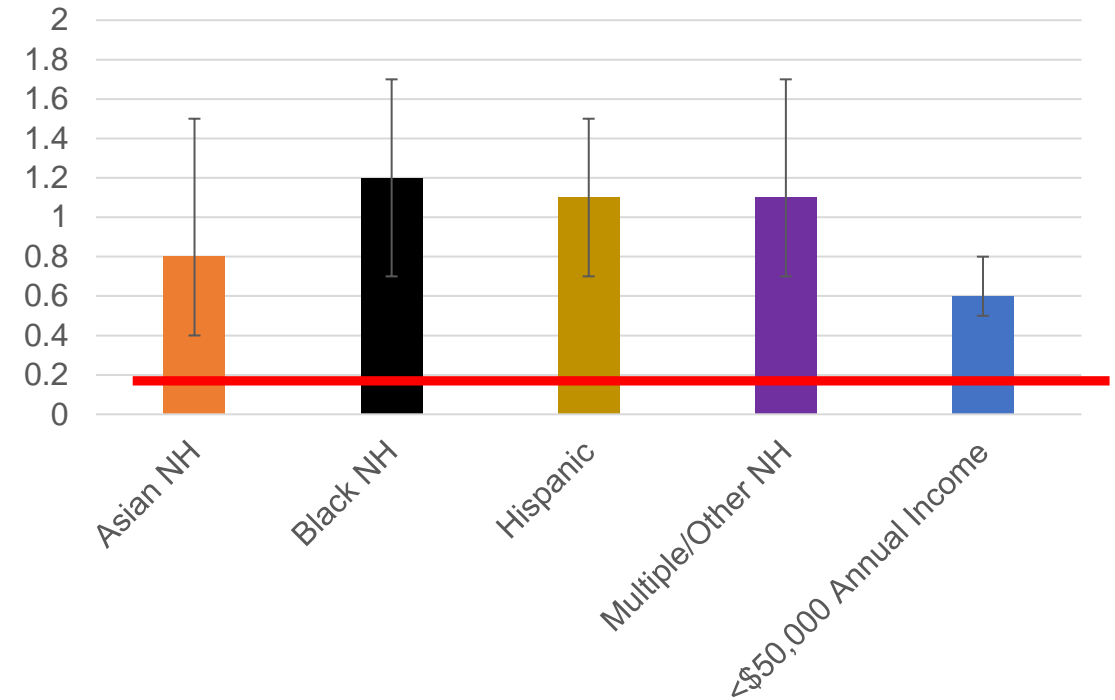


Pediatric Trends in Physician-diagnosis by Race and Household Income 2011-2018

2011 Odds of Physician-diagnosed FA
(among patients reporting convincing FA)



2018 Odds of Physician-diagnosed FA
(among patients reporting convincing FA)

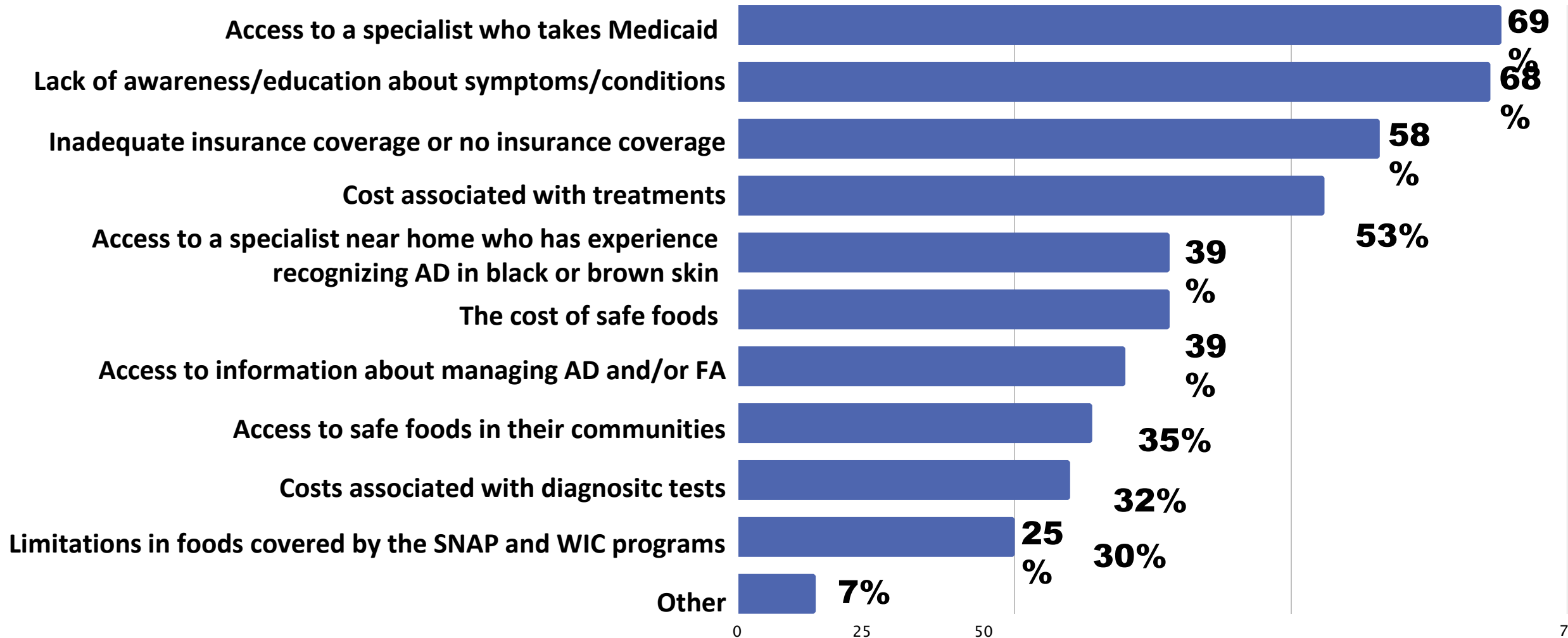


Eczema / Atopic Dermatitis

- Highest rates observed in non-Hispanic Black children
- Non-Hispanic Black and Hispanic children develop more severe cases relative to non-Hispanic White Children
- Currently, few resources to identify eczema in different skin tones
 - **Most pictures only of lighter skin tones**
- **Early detection of high-risk infants is key for early intervention!**



Challenges Reported by Patients of Color in Getting Diagnosis and Treatment for AD or Food Allergy



Access to Care

Medicaid-enrolled U.S. children with FA less likely to receive guideline-informed care

Children of color and those living in high poverty counties were:

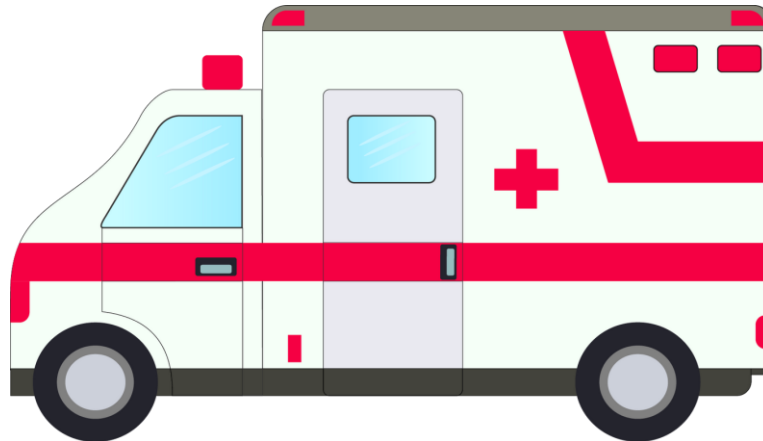
- Less likely to have visited an allergist for FA or receive diagnostic testing
- More likely to have an FA-related ED visit compared with White children and those not living in a high-poverty county



Outcomes and Factors Associated with Pre-Hospital Treatment of Pediatric Anaphylaxis

Children with Medicaid received pre-ED EPI **less frequently** than children with private insurance (24.5% v. 43.8%, $p=.001$).

Medicaid insurance was associated with **decreased likelihood of pre-hospital EPI** (OR .33 [95% CI .16-.66]).



Access to Treatment

- OIT and SLIT are treatments offered by limited number of allergists and mostly out of pocket
- Additional costs for office visits, travel, time off work, unanticipated ED visits



OIT Awareness

- Among a nationally representative sample of FA patients and pediatric caregivers, awareness of OIT is low
 - 72% of respondents did not know what OIT was prior to the survey
- Significantly greater odds of reporting any OIT awareness among:
 - Households with income >\$100,000
 - (odds ratio 2.0; 95% confidence interval 1.2-3.4)
 - Those with college degree
 - (odds ratio 1.9; 95% confidence interval 1.2-3.0)

Compared to low income households and those without a college degree





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Economic Impact

Economic Impact of Food Allergies in the US

Cross-sectional survey administered to 1,643 US caregivers of children with current food allergy to determine:

Frequency of Allergic Events & Associated Costs:

Medical

- Hospitalizations
- ED visits

Out-of-pocket

- Special diets
- Changes in childcare or schools due to child's food allergy

Lost labor productivity

- Caregiver time spent attending medical visits for food allergic children

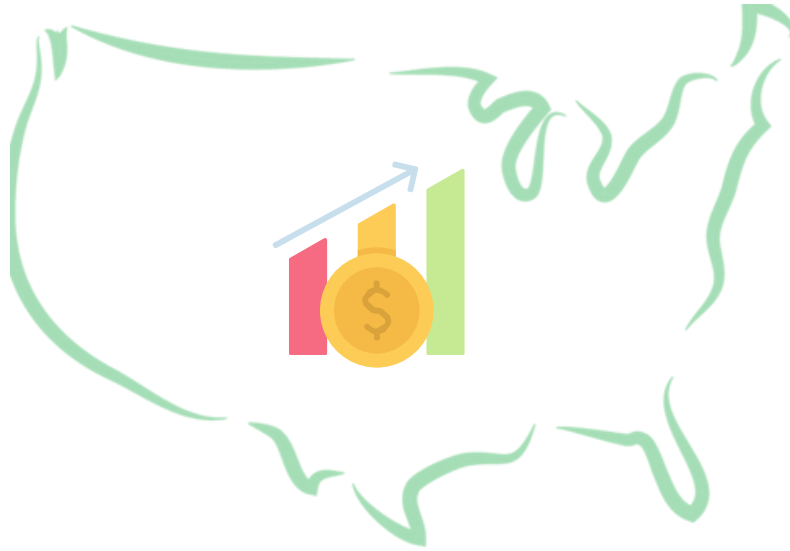
Food allergy-related opportunity costs

- Forgone labor market activities (e.g., job loss, part-time work)



Economic Impact of Food Allergy

Overall Economic Cost



\$ 24.8 Billion

Direct Medical Costs



\$ 4.3 Billion

Family Cost



\$ 20.5 Billion

***\$4,184 per year/per
child***

Direct Medical Costs*

Characteristic	Children With Visit, % (SE)	Visits per Child, Mean (SE)	Cost, US \$		
			Visit	Child	Overall Annual (in Millions)
Visits					
Pediatrician	42 (2)	.82 (.05)**	112	92	543
Allergist	41 (2)	.79 (.05)**	175	138	819
Pulmonologist	14 (1)	.07 (.01)**	175	12	71
Nutritionist	17 (1)	.16 (.04)**	100	16	96
Alternative Provider	17 (1)	.23 (.05)**	100	23	136
Emergency Department	13 (1)	.18 (.02)***	711	129	764
Inpatient Hospitalization Stays	4 (1)	.05 (.01)***	6269	314	1863
Total Direct Medical Costs				\$724 child	\$4.3 Billion

*Direct medical costs are medical costs borne by the health care system associated with prevention, diagnosis, and treatment of food allergies.

**Source: Hospital Outpatient Prospective Payment System

***Source: Patel et al. Estimating the economic burden of food-induced allergic reactions and anaphylaxis in the United States.

Out-of-Pocket Costs

Variable	% Reporting Cost (SE)	Mean Direct Out-of-Pocket Costs, US\$ (SE)	Cost Per Child, US\$	Overall Annual Cost (in Millions), US\$
Non-traditional medicine	15 (1.6)	123 (30)	19	110
Costs associated with special diets and allergen-free food	37.7 (2.0)	756 (59)	285	1689
Additional/change in child care	6.7 (0.8)	2158 (323)	145	857
Legal guidance	2.3 (0.6)	402 (122)	9	55
Counseling or mental health services	4.5 (0.7)	571 (123)	26	152
Special summer camp	3 (0.7)	702 (183)	21	125
A change in schools was needed due to food allergy	4.2 (0.7)	2611 (497)	110	650
Other expenses (e.g., cleaning supplies)	9.5 (1.1)	396 (86)	36	216
Any out-of-pocket costs	74.3 (2.1)	1252 (90)	931	5516

Out-of-pocket costs: medical costs borne by patient associated with the prevention, diagnosis, and treatment of food allergies. Includes all costs associated with protecting the child from exposure to allergens, including special child care arrangements. The out-of-pocket costs exclude the top 1% of reported costs in each category.

Comparing WTP & Measure of Actual Cost

Characteristic	Annual Costs, US\$			
			95% CI	
	Total (in Billions)	Per Child	Total (in Billions)	Per Child
Willingness to Pay (WTP)	20.8	3504	(15.7-25.7)	(2652-4344)
Costs borne by families				
Out-of-pocket treatment	5.5	931	(4.7-6.4)	(793-1080)
Lost labor productivity	0.77	130	(0.53-1.0)	(89-175)
Opportunity	14.2	2399	(10.5-18.4)	(1771-3104)
Total				
Direct medical costs	4.3	724	(2.8-6.3)	(472-1063)
Reported costs borne by families	20.5	3457	(16.7-24.9)	(2816-4208)
Reported costs	24.8	4184	(20.6-29.4)	(3475-4960)

Direct Out-of-Pocket Costs by Household Income

Type of Cost	Mean Annual Costs (SE), US\$		
	<\$50K	\$50K-99K	≥\$100K
Total Direct Costs borne by health care system	1374 (274)	1024 (125)	940 (128)
ER and Hospitalization costs*	1021 (209)	434 (106)	416 (94)
Specialist costs**	228 (21)	330 (27)	311 (18)
Total Out-of-Pocket Costs borne by families	3174 (858)	3434 (658)	5062 (1168)
Medication costs***	171 (26)	275 (30)	366 (44)
Special food costs	744 (216)	941 (230)	1545 (347)

*p<0.05, **p<0.01, ***p<0.001 for F-test of equality of means across groups.

Families with Low Income

Spend 2.5x more on FA **ED Visits and hospitalizations**

Spend less on **specialty** visits

Spend less on out-of-pocket costs for **medications**





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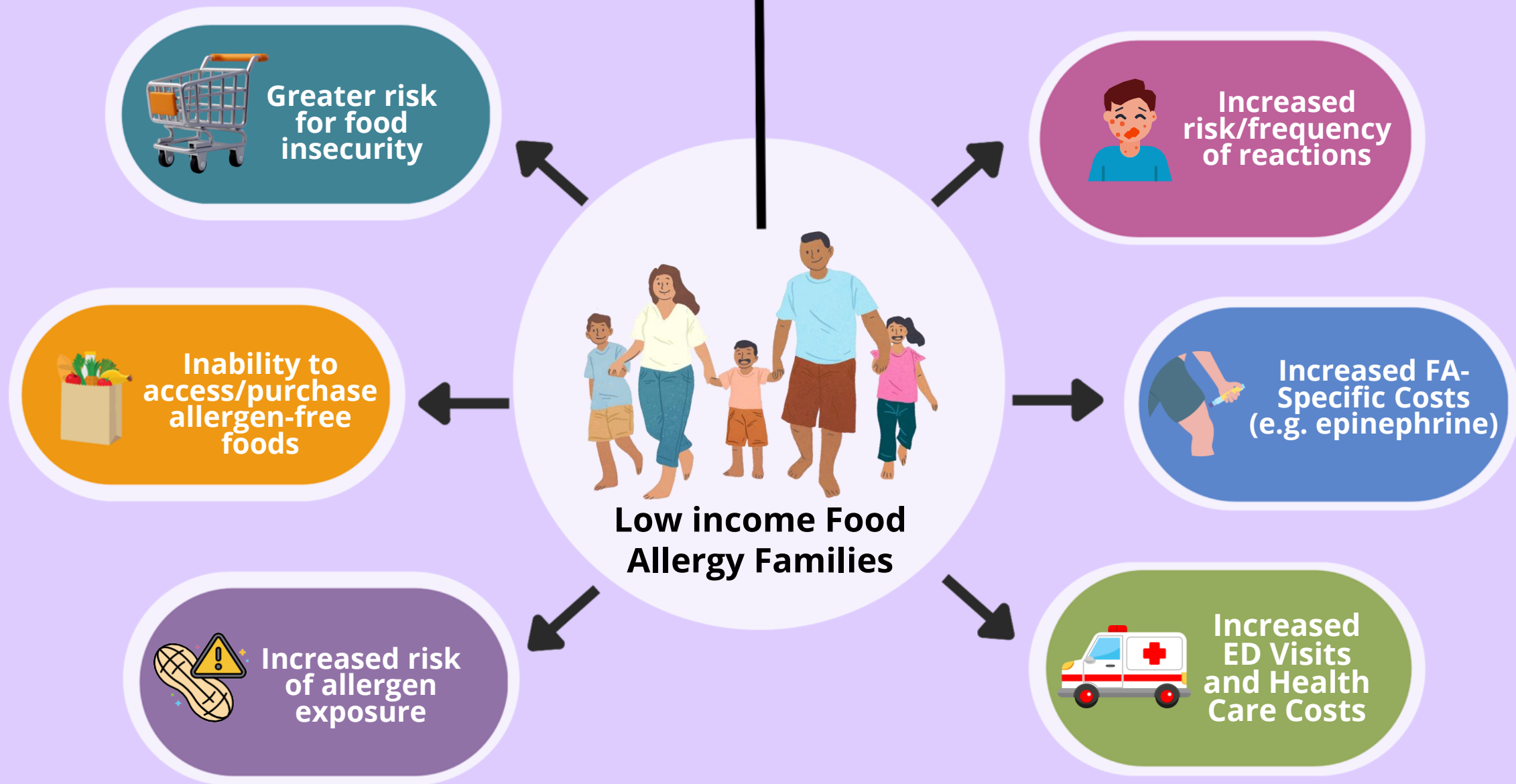
Food Insecurity

Food Insecurity



"I would say the biggest challenge is finding food that fits all of his restrictions"





Food Insecurity Screening

Many physicians have limited insecurity screening tools/resources available in their practices

It is often difficult to provide patients with comprehensive support or "prescribe" foods that are safe and nutritious



1. Bilaver LA, Das R, Martinez E, Brown E, Gupta RS, Love M. Addressing the social needs of individuals with food allergy and celiac disease during COVID-19: A new practice model for sustained social care. *Soc Work Health Care*. 2021;60(2):187-196. doi: 10.1080/00981389.2021.1904323. Epub 2021 Mar 28. PMID: 33775233.
2. Shroba J, Das R, Bilaver L, et al. Food Insecurity in the Food Allergic Population: A Work Group Report of the AAAAI Adverse Reactions to Foods Committee. *J Allergy Clin Immunol Pract*. 2022;10(1):81-90. doi:10.1016/j.jaip.2021.10.058

Food Insecurity in the Food Allergic Population: A work group report of the AAAAI Adverse Reactions to Foods Committee


Aim of Study: To survey AAAAI members about food insecurity knowledge and practices

59 responses received from practices allergists, immunologist, fellows in training, residents, and allied health members over survey period [Sept-Oct 2020]

Patients were on average White (63.4%), Black (14.8%), Hispanic/Latinx (12.6%), Asian (7.4%) and Other (5.0%)

Insurance coverage for most patients was either private (adult 62.7%, child 60.0%) or public (adult 37.2%, child 43.3%)

Findings



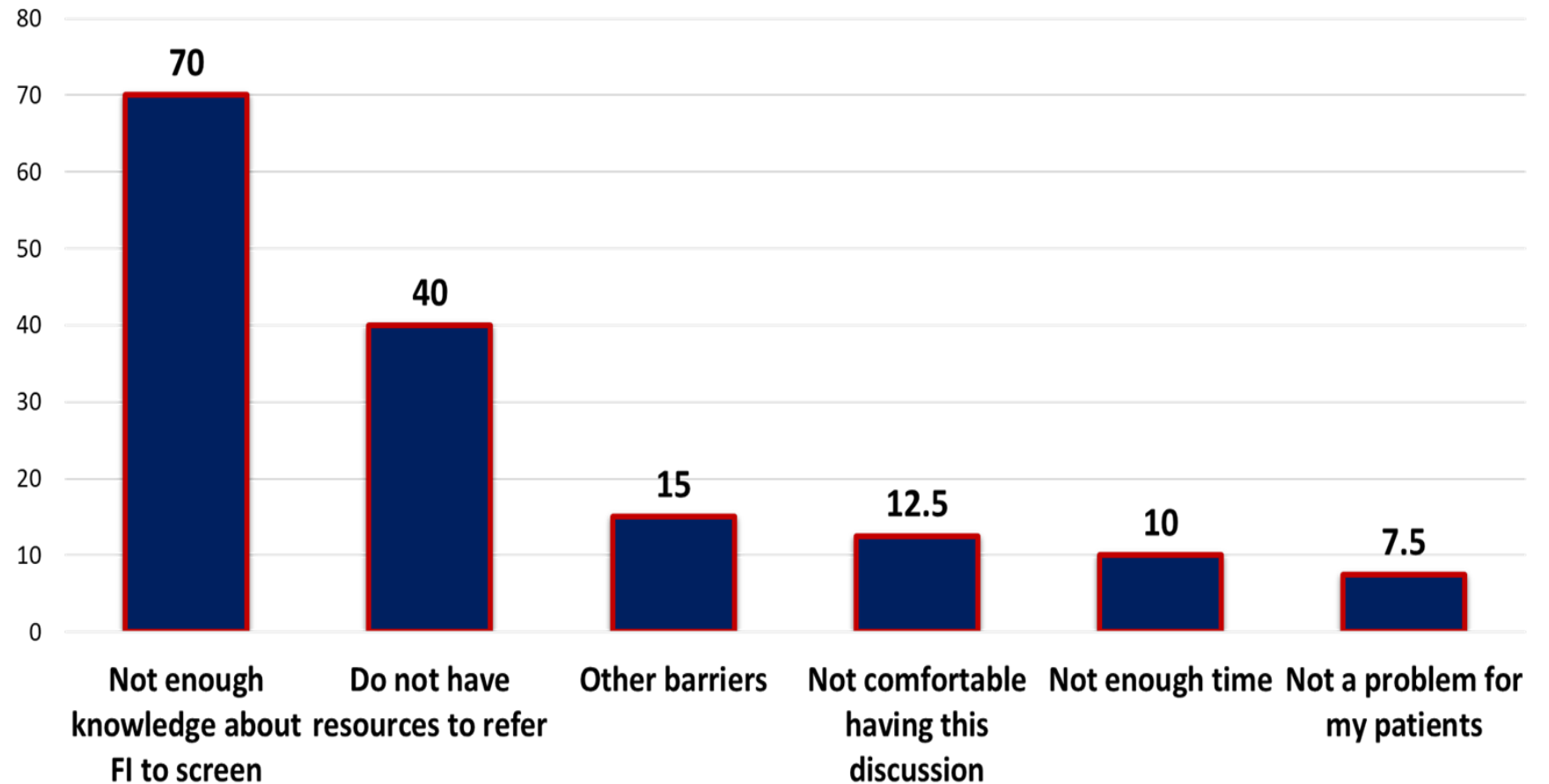
The majority of respondents **did not routinely screen** their patients for FI
(75.5%)

71.2% of respondents **were unaware** of whether their patients with FA faced FI
within the past 6 months

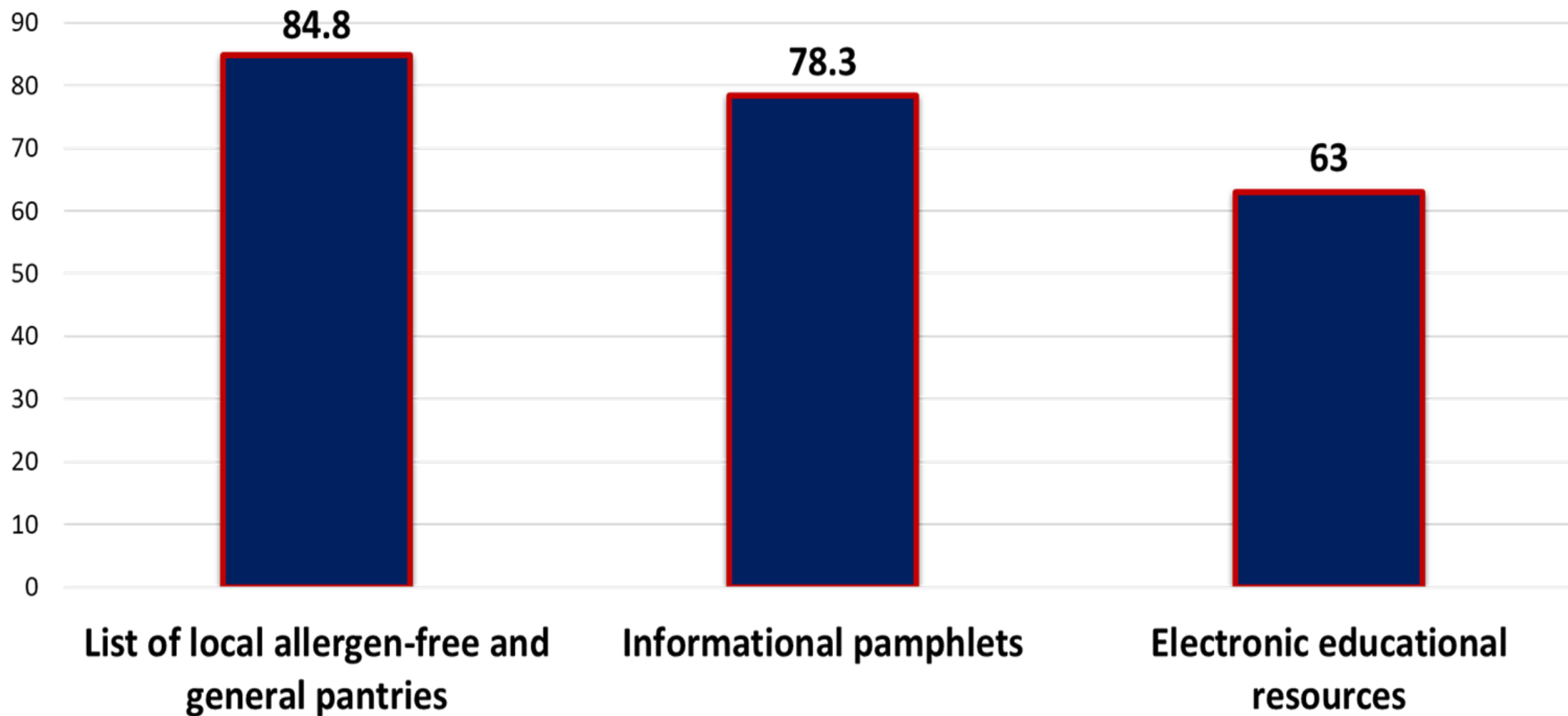
15.1% reported screening patients **with FA**

Most Endorsed Barriers

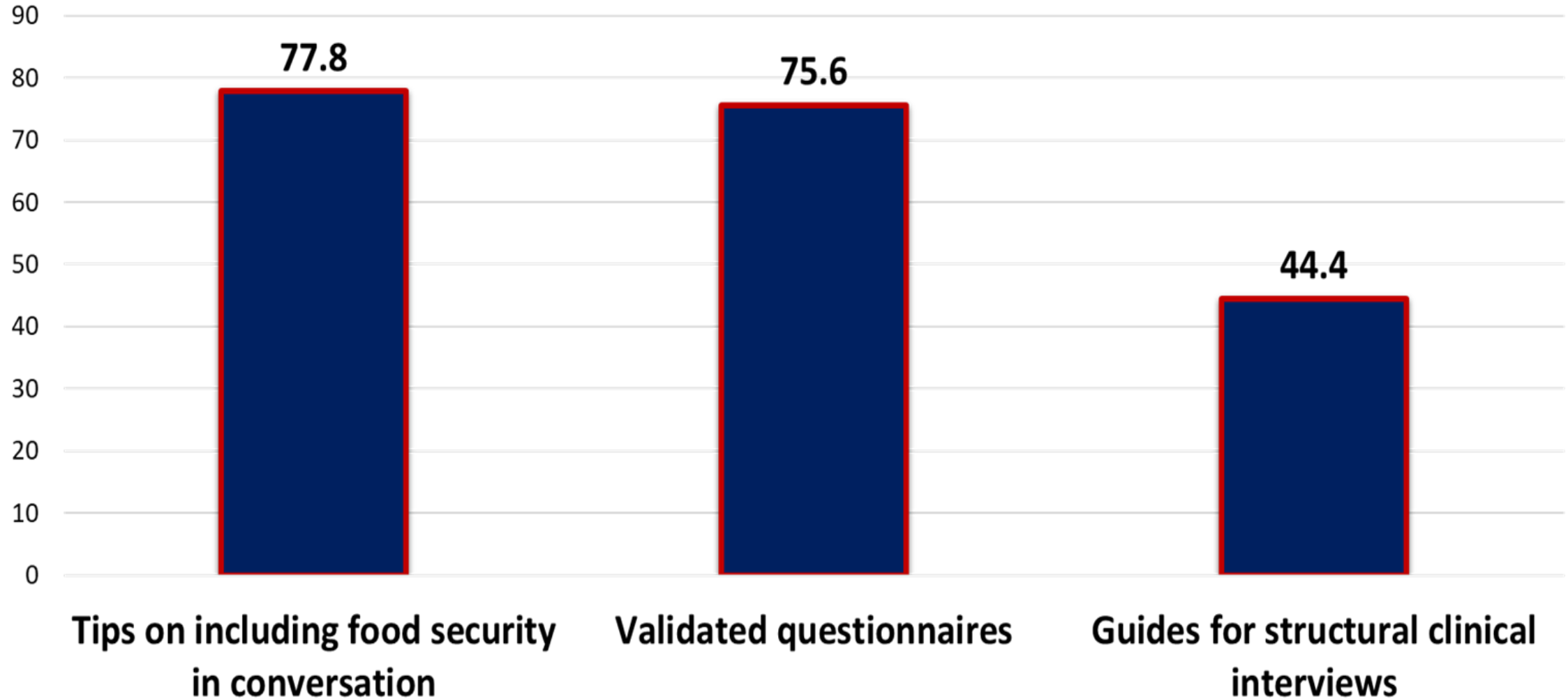
- Not enough knowledge about FI to screen patients (70%)
- Do not have resources to refer to food insecure patients (40%)



Types of Resources Preferred



Types of Tools Preferred





CFAAR

Center for Food Allergy
& Asthma Research

What Can We Do?

Incorporate Food Insecurity Screening into Clinic Workflow

- **Existing food insecurity instruments include:**
 - U.S. Household Food Security Survey Module (USDA)
 - Six-Item Short Form of the Food Security Survey Module (USDA)
 - American Academy of Pediatrics Recommended Hunger Vital Sign™

Example questions to include from Hunger Vital Sign™:

- 1. In the past 12 months, we worried whether our food would run out before we got money to buy more.**
 - Often true
 - Sometimes true
 - Never true
- 2. In the past 12 months, the food we bought just did not last and we did not have money to get more.**
 - Often true
 - Sometimes true
 - Never true



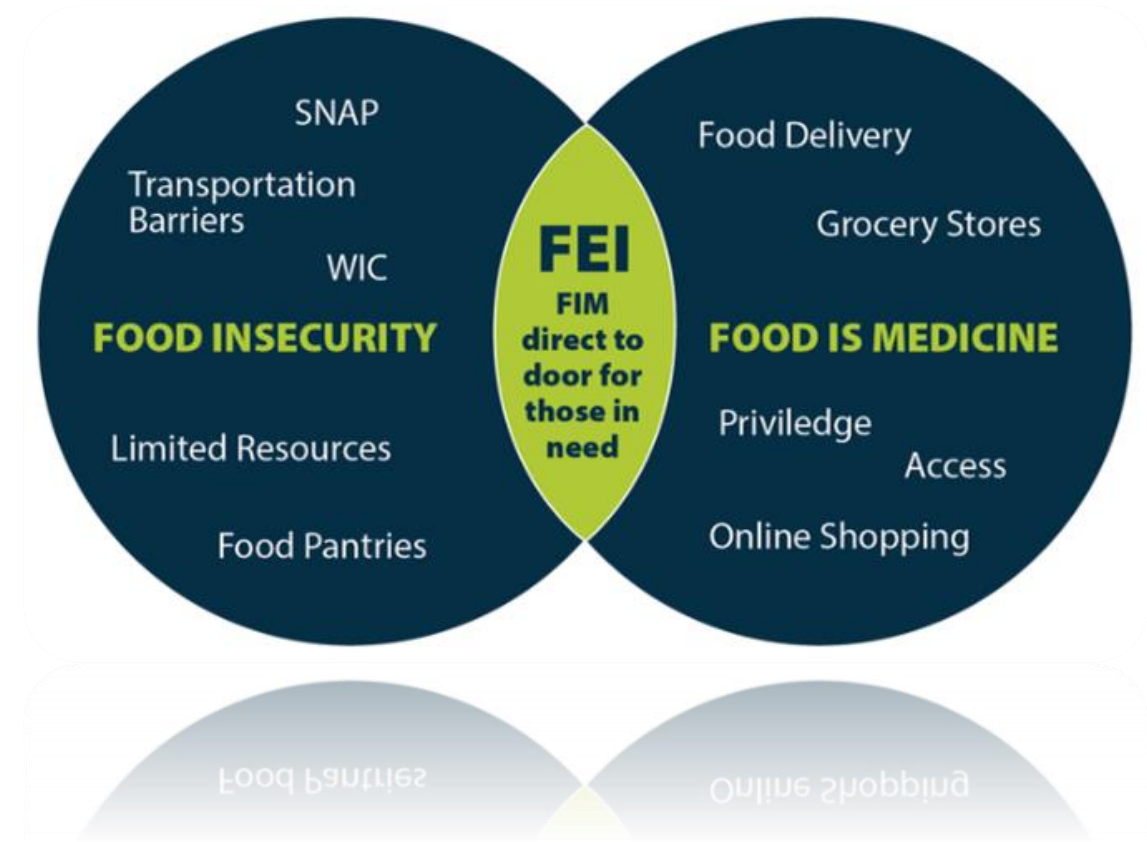
Identify Opportunities for Partnerships and Referrals

- Connect with food pantries who serve patients with FA

- <https://foodequalityinitiative.org/>
- <https://freefrommarket.com/contact-us/>
- <https://fooddiversity.org/>
- <https://securingsafefood.org/>



securing safe food



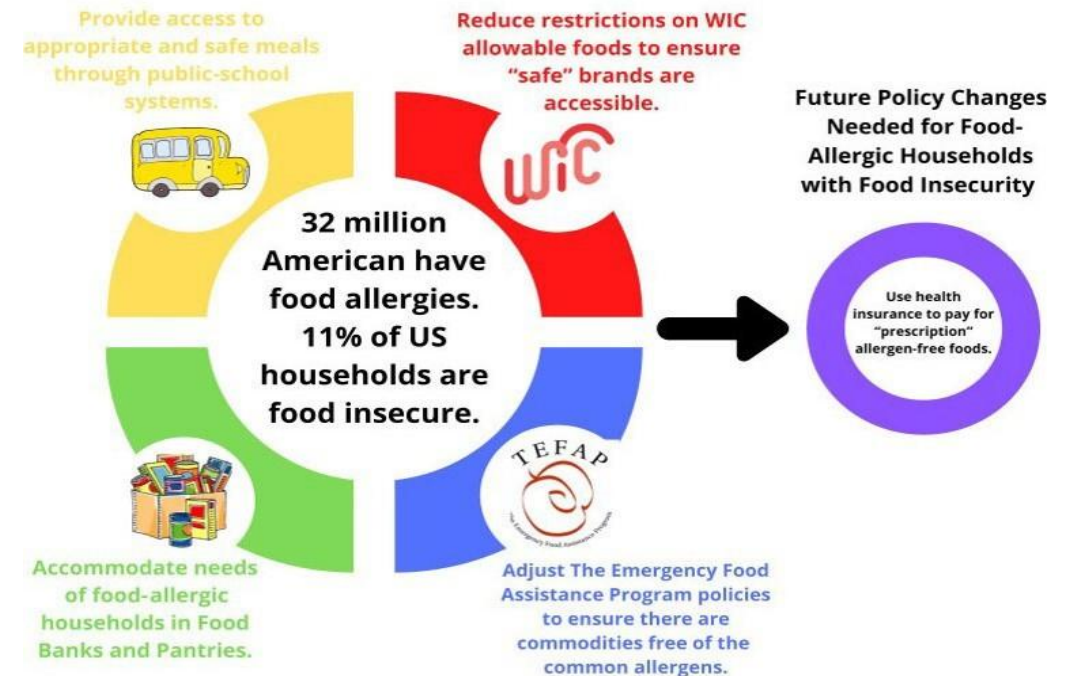
Join Working Groups and Advocate for Policy Change

Working Groups:

- ACAAI and AAAAI Working Group

Advocate for policy changes:

- Strengthening federal nutrition programs
- Fewer restrictions on substitutions in the WIC program with more offerings of allergy-friendly foods and nutritionally equivalent offerings
- Insurance coverage on food as medicine



Improve Racial Representation in Food Allergy Research

Delphi method:

Discussions food allergy clinicians, advocacy leaders, community-engaged researchers, and patients

Created **18 recommendations** to combat inequitable research paradigms and increase participation of racially underrepresented populations in FA research.

4 Domains:

**Community
Partnership**

**Intentional
Engagement and
Messaging**

**Recruitment
Activities**

Dissemination

Increase Awareness and Policies for New Treatments

- Educate patients on what different treatments are available, what might work best for them, what is accessible, etc.
- Consider hosting community-facing events or virtual panels to reach patient population
- Advocate for FDA Approval and Insurance coverage for new treatments



Share Management Tools: Food Allergy Passport

Personalized tool that helps caregivers and children manage their food allergies more easily and with greater confidence.

Available for free on CFAAR website.
Create your own/share with patients:
www.foodallergypassport.com!

After filling out personalized FA Passport™, it can be printed or sent via email.



Share Management Tools: Food Allergy Workbook

Managing Food Allergies Workbook

Parent's checklist: ☒

- ☐ Review common signs of an allergic reaction
- ☐ Teach your child where important reaction information is located in passport
- ☐ Review where epinephrine is kept at home and at school

For Parent and Child: Review Details of Past Reactions

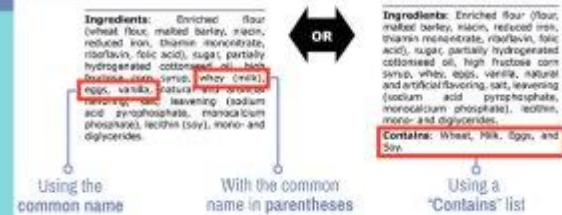
What food was eaten? _____
What were your symptoms? _____
What actions were taken? _____
What worked? _____
What did not work? _____
What new actions will you take? _____

Pro Tip: Make sure to share these details with your allergist at your child's next appointment.

Create a list of questions you would like to ask the allergist. Make sure to jot down their answers, too!

Food Label Tips

ALLERGENS CAN BE LISTED IN ONE OF THREE WAYS



Pro Tip:

Read every label, every time.
Ingredients in packaged foods may change without warning.

WHAT ARE PRECAUTIONARY LABELS?

These labels include statements like:

- "May Contain..."
- "Processed in a facility with..."
- "Processed on equipment that also processes..."



Manufacturers do NOT have to include these statements NOR do they have to include "traces" of allergens that have come about through processing

Allergists normally tell patients to AVOID these products to prevent eating unintentional traces of an allergen due to cross contamination

Talking about food allergies with your child

Keep It SIMPLE

- Use **language** that is right for your child's age.
- Talk about the **"unsafe foods"** that make them very sick.
- **Show them** what the "unsafe foods" are and common snacks that may include them. When at the grocery store, point out gallons of milk or cartons of eggs to show your child what they commonly look like.
- Teach them the importance of only eating foods that are given to them by their parents or trusted adults aware of the food allergy.

Stick To The FACTS

- Describe **accurate information** about allergic reactions and allergens.
- **Be honest** when you answer questions, but don't magnify or "over-share" things you read on social media.
- **Be calm** and use a positive tone, even if you may feel anxious or fearful about allergic reactions. As your child's role model, they will follow your lead.
- Emphasize that they are **NOT alone!** There are other kids, just like them, who have food allergies. In fact, 1 in 13 kids in the U.S. are just like them!
- Most importantly, they should know how to find an adult that can help them if they feel sick.
- Showing them where their emergency action plan and their medication that needs to be taken during an allergic reaction (epinephrine) can help them prepare if the event were to occur

Helpful Videos



<https://youtu.be/Fne6rMAOT9c>
<https://youtu.be/HjU5d1gE3E8>
<https://youtu.be/sXMUOW3FEv8>

Share Management Tools: Peer-to-Peer Educational Videos



K – 3rd Grade



4th - 7th Grade



8th - 12th Grade

Available at cfaar.northwestern.edu

Provide Resources for Patients



Advocacy and Support Groups



Conclusion

Food allergy prevalence, economic impact, outcomes, access to timely diagnosis and care, and access to safe foods differ significantly by race and socioeconomic status

Physicians, allergists, industry leaders, and policy makers must continue to work together to address these disparities through prioritizing comprehensive education, screening, and systematic policy change to achieve equitable care for all patients



**Do the best you can until
you know better. Then when
you know better, do better.**

- Maya Angelou



CFAAR'S COMMUNITY RESOURCE CORNER



Create An Asthma Action Plan

Full Name

Patient's Age

Doctor's Name

Doctor's Phone Number

Next

FOOD ALLERGY PASSPORT

My full name is: _____
I like to be called: _____
Date of birth: _____
My doctor's name: _____
My doctor's phone: _____
My guardian's name: _____
My guardian's phone: _____
Secondary contact's name: _____
Secondary contact phone: _____

YOU CAN FIND MY LIFESAVING MEDICATION HERE:

Epinephrine Auto injector Name: _____
Location: _____

IN CASE OF AN EMERGENCY **CALL 9-1-1**

MY FOOD ALLERGIES



FISH

Yes No



EGG

Yes No



PEANUT

Yes No



MILK

Yes No



SHELLFISH

Yes No



WHEAT

Yes No



TREE NUTS

Yes No



SOY

Yes No



SESAME

Yes No



Browse all CFAAR Resources
here or by visiting
cfaar.northwestern.edu

June 27-29 | Chicago, IL

2025 CFAAR FOOD ALLERGY SUMMIT

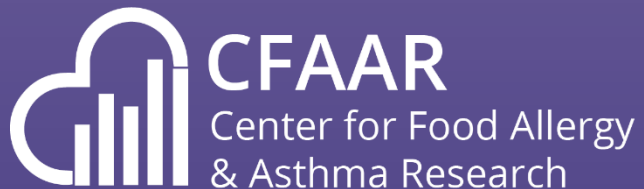
Advancing Food Allergy Prevention,
Equity, & Pediatric Education

<https://www.feinberg.northwestern.edu/sites/cfaar/events/index.html>

Thank you!

Connect with CFAAR

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