FORM 4 - SEVERE ALLERGY/ANAPHYLAXIS MANAGEMENT & EMERGENCY RESPONSE PLAN

STUDENT DETAILS

SCHOOL:	YEAR:	INSERT PHOTO HERE
NAME	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR 1:	
RELATIONSHIP TO STUDENT:	DOCTOR 2:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE: HOSPITAL:	
NAME:	TELEPHONE:	
ADDRESS:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE YES ☐ NO ☐	
RELATIONSHIP TO STUDENT:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐ **IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.**	
TELEPHONE: (W) (H) (M)	STUDENT HAS A MEDICALERT BRACELET/PENDANT YES ☐ NO ☐ IF YES PROVIDE DETAILS:	

SECTION A – STUDENT HEALTH CARE PLANNING – TO BE COMPLETED BY PARENT/CARER

LIST SPECIFIC ALLERGENS AND MOST RECENT REACTIONS IN THE TABLE BELOW

MY CHILD IS ALLERGIC TO:	For each allergen provide specific information (e.g. peanuts – even small quantities)	Where applicable, please indicate your child's most recent reaction to the allergen (e.g. anaphylaxis, hay fever, hives, eczema).
Peanuts		
Tree Nuts		
Milk		
Eggs		
Soy Products		
Wheat Products		
Shellfish/Fish		
Insect Stings		
Medication		
Other/Unknown		

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME: SCHOOL: DOB:

SECTION B - DAILY MANAGEMENT

PROVIDE ADVICE THAT WOULD ASSIST IN THE MANAGEMENT OF YOUR CHILD'S ALLERGY.

SECTION C – STAFF TRAINING

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO MANAGE YOUR CHILD'S CONDITION OR NEEDS? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL).

A. FOR DAILY MANAGEMENT? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

B. IN AN EMERGENCY? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

SECTION D – EMERGENCY RESPONSE – AS PER ANAPHYLAXIS ACTION PLAN ATTACHED

SECTION E – MEDICATION

	INSTRUCTIONS					
	MEDICATION 1		MEDICATION 2		MEDICATION 3	
NAME OF MEDICATION						
EXPIRY DATE						
DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL						
DURATION (DATES)	FROM : TO:		FROM : TO:		FROM : TO:	
ROUTE OF ADMINISTRATION						
ADMINISTRATION (TICK APPROPRIATE BOX)	BY SELF REQUIRES ASSISTANCE	☐ ☐	BY SELF REQUIRES ASSISTANCE	☐ ☐	BY SELF REQUIRES ASSISTANCE	☐ ☐
STORAGE INSTRUCTIONS (TICK APPROPRIATE BOX(ES)	STORED AT SCHOOL	☐	STORED AT SCHOOL	☐	STORED AT SCHOOL	☐
	KEPT AND MANAGED BY SELF	☐	KEPT AND MANAGED BY SELF	☐	KEPT AND MANAGED BY SELF	☐
	REFRIGERATE	☐	REFRIGERATE	☐	REFRIGERATE	☐
	KEEP OUT OF SUNLIGHT	☐	KEEP OUT OF SUNLIGHT	☐	KEEP OUT OF SUNLIGHT	☐
	OTHER	☐	OTHER	☐	OTHER	☐

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME:	SCHOOL:	DOB:

SECTION F – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, MEDICAL PRACTITIONER AND PARENT/CARER – TO BE COMPLETED BY ALL

THIS AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND MEDICAL PRACTITIONER AS SET OUT IN THE ALLERGY/ANAPHYLAXIS MANAGEMENT AND EMERGENCY RESPONSE PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS

.

PRINCIPAL: **DATE:**	**MEDICAL PRACTITIONER (SIGNATURE REQUIRED)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

OFFICE USE ONLY

IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐ DATE:

TYPE OF TRAINING:

NAME OF PERSON(S)TO BE TRAINED:

PRINCIPAL SIGNATURE:

COMPLETE AND ATTACH THE STUDENT HEALTH CARE SUMMARY FORM TO THE FRONT OF THIS DOCUMENT

ANAPHYLAXIS ACTION AND EMERGENCY RESPONSE PLAN

Action plan for Anaphylaxis

Name: _____

Date of birth: _____

Photo

Known severe allergies: _____

Parent/carer name(s)

Work Ph:

Home Ph:

Mobile Ph:

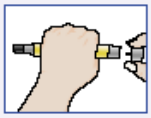
Plan prepared by:

Dr.

Signed

Date

How to give EpiPen® or EpiPen® Jr



1. Form fist around EpiPen® and pull off grey cap.

2. Place black end against outer mid-thigh.

3. Push down **HARD** until a click is heard or felt and hold in place for 10 seconds.

4. Remove EpiPen® and be careful not to touch the needle. Massage the injection site for 10 seconds.

MILD TO MODERATE ALLERGIC REACTION

- swelling of lips, face, eyes
- hives or welts
- abdominal pain, vomiting

ACTION

- stay with child and call for help
- give medications (if prescribed) .....
- locate EpiPen® or EpiPen® Jr
- contact parent/carer

watch for signs of Anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- difficulty/noisy breathing
- swelling of tongue
- swelling/tightness in throat
- difficulty talking and/or hoarse voice
- wheeze or persistent cough
- loss of consciousness and/or collapse
- pale and floppy (young children)

ACTION

1 Give EpiPen® or EpiPen® Jr

2 Call ambulance. Telephone 000

3 Contact parent/carer

If In doubt, give EpIPen® or EpIPen® Jr

Additional Instructions

ascia
australasian society of clinical immunology and allergy inc.

www.allergy.org.au

Reference Source: Anaphylaxis Australia: To download go to http://www.allergy.org.au/images/stories/anaphylaxis/anaphylaxis_plan_child_au.pdf