



# FORM 4 - SEVERE ALLERGY/ANAPHYLAXIS MANAGEMENT AND EMERGENCY RESPONSE PLAN

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Year: \_\_\_\_\_

Teacher: \_\_\_\_\_ Form: \_\_\_\_\_

## SECTION A: Student Health Care Planning – to be completed by parent/carer (Please 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)	Describe your child’s most recent symptoms and date of reaction to the allergen (e.g. anaphylaxis, hay fever, hives, eczema).
Peanuts	<input type="checkbox"/>		
Tree Nuts	<input type="checkbox"/>		
Milk	<input type="checkbox"/>		
Eggs	<input type="checkbox"/>		
Soy Products	<input type="checkbox"/>		
Wheat Products	<input type="checkbox"/>		
Shellfish	<input type="checkbox"/>		
Fish	<input type="checkbox"/>		
Insect Stings or Bites (Please specify insect(s) if known)	<input type="checkbox"/>		
Medication (Please specify medicine(s) if known)	<input type="checkbox"/>		
Other/Unknown (Please specify food(s) if known)	<input type="checkbox"/>		

## SECTION B: Daily Management

List strategies that would minimise the risk of exposure to known allergens: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SECTION C: Medication Instructions** (Note: All medication must be provided by parents/carers)

	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	<input type="checkbox"/>	By self	<input type="checkbox"/>	By self	<input type="checkbox"/>
	Requires assistance	<input type="checkbox"/>	Requires assistance	<input type="checkbox"/>	Requires assistance	<input type="checkbox"/>
Storage instructions – tick appropriate box(es)	Stored at school	<input type="checkbox"/>	Stored at school	<input type="checkbox"/>	Stored at school	<input type="checkbox"/>
	Kept and managed by self	<input type="checkbox"/>	Kept and managed by self	<input type="checkbox"/>	Kept and managed by self	<input type="checkbox"/>
	Refrigerate	<input type="checkbox"/>	Refrigerate	<input type="checkbox"/>	Refrigerate	<input type="checkbox"/>
	Keep out of sunlight	<input type="checkbox"/>	Keep out of sunlight	<input type="checkbox"/>	Keep out of sunlight	<input type="checkbox"/>
	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>	Other	<input type="checkbox"/>

**SECTION D: Emergency Response – as per anaphylaxis (ASCIA) action plan attached** (This must be completed by your child's medical practitioner).

If unavailable go to the ASCIA website for Action Plans: <https://www.allergy.org.au/health-professionals>

## SECTION E: Authority to Act

This severe allergy/anaphylaxis management and emergency response plan authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Carer Name:  _____	Medical Practitioner Name and Medical Practice:  _____	Review Date:
Signature:  _____	Signature:  _____	
Date: _____	Provider Number: _____	
	Date: _____	

<b>OFFICE USE ONLY</b>	Date uploaded on SIS: / /
Is specific staff training required? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>	Date received: / /
Type of training:	Date of training: / /
Training service provider:	
Name of person/s to be trained:	

**When completed, please attach the *Student Health Care Summary* to the front of this document.**

ASCIA Emergency Action Plans are regularly updated. To ensure you are using the most current documentation, go to the ASCIA website: <https://www.allergy.org.au/health-professionals>