# FORM 5 - MILD TO MODERATE ALLERGY

## Date of Birth: Year: 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. hay fever, hives, eczema).
Peanuts		
Tree Nuts		
Milk		
Eggs		
Soy Products		
Wheat Products		
Shellfish		
Fish		
Insect Stings or Bites (Please specify insect(s) if known)		
Medication (Please specify which medication(s) if known)		
Other/Unknown(Please specify food(s) if known)		

## **Section B - Daily Management**

Name:

List strategies that would minimise the risk of exposure to known allergens.

Section C – Medication Instructions (Note: 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:				
Route of administration							
Administration Tick appropriate box	By self Requires assistance		By self Requires assistance		By self Requires assistance		
	doolotarioo						
Storage instructions Tick appropriate	Stored at school		Stored at school		Stored at school		
box(es)	Refrigerate		Refrigerate		Refrigerate		
	Keep out of sunlight		Keep out of sunlight		Keep out of sunlight		
	Other		Other		Other		

### Section D - Emergency Response

As per ASCIA action plan attached (This must be completed by your child's medical practitioner). Go to the ASCIA website for Action Plans and further information: <u>https://www.allergy.org.au/health-professionals</u>

#### Section E – Authority to Act

This mild to moderate allergy 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:	Medical practitioner's name (and Mec required):	Review Date:	
Date:	Medical Practitioners Signature:		
	Provider Number:	Date:	

### When completed, please attach to the *Student Health Care Summary*.

OFFICE USE ONLY		
Date received:		Date uploaded on SIS:
Is specific staff training required? Ye	es 🗌 No 🔲:	Type of training:
Training service provider:		
Name of person/s to be trained:		Date of training: