

In response to your completion of Form 1, please complete this form to provide comprehensive detail of your child's health condition.

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

**Name:** \_\_\_\_\_ **Year:** \_\_\_\_\_ **Form:** \_\_\_\_\_ **Teacher:** \_\_\_\_\_

### 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 know allergens.

---

---

---

---

---

---

---

---

---

---

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

**Section D – Emergency Response – As per anaphylaxis (ASCI) action plan attached (This must be completed by your child's medical practitioner). If unavailable go to <http://www.allergy.org.au/content/view/10/3/> for Anaphylaxis Emergency Plans and Management Forms**

### Section E – Authority to Act

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

<b>Parent/Carer:</b> <b>Date:</b>	<b>Medical Practitioner Name and Medical Practice</b>  <b>Medical Practitioners Signature:</b> <b>Provider Number:</b>	<b>Review Date:</b>  <b>Date:</b>
--------------------------------------	---	---

---

**OFFICE USE ONLY**

---

Date received:

Date uploaded on SIS:

Is specific staff training required? **Yes**  **No** :

Type of training:

Training service provider:

Name of person/s to be trained:

Date of training:

**FORM 4 PAGE 2 OF 2**

---

# ACTION PLAN FOR Anaphylaxis

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_



Allergens to be avoided: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Family/carer name(s): \_\_\_\_\_

\_\_\_\_\_

Work Ph: \_\_\_\_\_

Home Ph: \_\_\_\_\_

Mobile Ph: \_\_\_\_\_

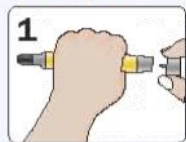
Plan prepared by: \_\_\_\_\_

Dr \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

## How to give EpiPen® or EpiPen® Jr



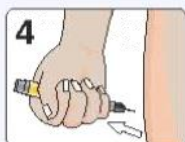
Form fist around EpiPen® and PULL OFF GREY SAFETY CAP.



PLACE BLACK END against outer mid-thigh (with or without clothing).



PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds.



REMOVE EpiPen® and DO NOT touch needle. Massage injection site for 10 seconds.

for use with EpiPen® or EpiPen® Jr adrenaline autoinjectors

### MILD TO MODERATE ALLERGIC REACTION

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

### ACTION

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



**Watch for any one of the following signs of Anaphylaxis**

### ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- difficult/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 (Aus) or 111 (NZ)**
- 3 Lay person flat and elevate legs. If breathing is difficult, allow to sit but do not stand**
- 4 Contact family/carer**
- 5 Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)**

**If in doubt, give EpiPen® or EpiPen® Jr**

EpiPen® Jr is generally prescribed for children aged 1-5 years.

\*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

Additional information \_\_\_\_\_