ST JOSEPH'S MILD TO MODERATE ALLERGY

MANAGEMENT & EMERGENCY RESPONSE PLAN

NAME:	**DATE OF BIRTH:**	**YEAR:**

1. Health condition – Allergy Mild ☐ Moderate ☐ (Please tick)

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	☐		
Tree Nuts	☐		
Milk	☐		
Eggs	☐		
Soy products	☐		
Wheat Products	☐		
Shellfish	☐		
Fish	☐		
Insect Stings or Bites (please specify insect(s) known)	☐		
Medication (Please specify medicine(s) if known)	☐		
Other (please specify food(s) if known)	☐		

Section B – Daily Management

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

Section C – Medication Instructions (Note: All medication must be provided by parents/caregivers)

	MEDICATION 1		**MEDICATION 2**		**MEDICATION3**	
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 Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐	Stored at school Kept and managed by self Refrigerate Keep out of sunlight Other	☐ ☐ ☐ ☐ ☐

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

http://www.allergy.org.au/images/stories/anaphylaxis/2014/ASCIA_Action_Plan_Allergic_REactions_2014.pdf for Anaphylaxis Emergency Plans and Management Forms

9. 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/Caregiver Signature: **Date:**	**Medical practitioner's signature: (if required)** **Date:**
Review Date:	
OFFICE USE ONLY	
Date received:	Date uploaded to SEQTA:
Is specific staff training required? YES ☐ NO ☐	Type of training
Training service provider:	
Name of person's to be trained:	Date of training:
When completed, add to student file.	