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

Willandra Primary School

Name: **Date of Birth:**
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	☐		
Tree Nuts	☐		
Milk	☐		
Eggs	☐		
Soy Products	☐		
Wheat Products	☐		
Shellfish	☐		
Fish	☐		
Insect Stings or Bites (Please specify insect(s) if known)	☐		
Medication (Please specify medicine(s) if known)	☐		
Other/Unknown(Please specify food(s) if known)	☐		

Section B - Daily Management

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

Section C – Medication Instructions

	Medication 1		**Medication 2**		**Medication 3**	
Name of medication						
Reason for 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	☐ ☐
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). 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 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 signature: **Date:**	**Medical Practitioner Name and Medical Practice** **Medical Practitioners Signature:** **Provider Number:** **Date:**	**Review Date:**

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& EMERGENCY RESPONSE PLAN

Name:		**Date of Birth:**
Year:	**Form:**	**Teacher:**
	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:

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

asci

www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

for use with Anapen® or Anapen® Jr adrenaline autoinjectors

Name: _____

Date of birth: _____

Photo

Confirmed allergens:

_____

_____

_____

Family/emergency contact name(s):

_____

Work Ph:

Home Ph:

Mobile Ph:

Plan prepared by:

Dr

_____

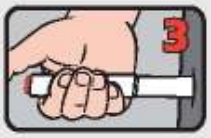
Signed

Date

How to give Anapen® or Anapen® Jr

PULL OFF BLACK NEEDLE SHIELD.

PULL OFF GREY SAFETY CAP from red button.



PLACE NEEDLE END FIRMLY against outer mid-thigh at 90° angle (with or without clothing).

PRESS RED BUTTON so it clicks and hold for 10 seconds. REMOVE Anapen® and DO NOT touch needle. Massage injection site for 10 seconds.

MILD TO MODERATE ALLERGIC REACTION

- swelling of lips, face, eyes
- hives or welts
- tingling mouth
- abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks**
- Stay with person and call for help
- Give medications (if prescribed) .....
  dose: .....
- Locate Anapen® or Anapen® Jr
- Contact family/emergency contact

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
- persistent dizziness or collapse
- pale and floppy (young children)

ACTION

1. **Lay person flat, do not stand or walk. If breathing is difficult allow to sit**
2. **Give Anapen® or Anapen® Jr**
3. **Phone ambulance - 000 (AU), 111 (NZ), 112 (mobile)**
4. **Contact family/emergency contact**
5. **Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)**

If in doubt, give Anapen® or Anapen® Jr

Anapen® 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

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ascia

www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

for use with EpiPen® or EpiPen® Jr adrenaline autoinjectors

Name: _____

Date of birth: _____

Photo

Confirmed allergens: _____

_____

_____

_____

Family/emergency contact 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.

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Additional information _____

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