FORM 5 - MILD TO MODERATE ALLERGY MANAGEMENT & EMERGENCY RESPONSE PLAN

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. 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

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	☐ ☐
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 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: https://www.allergy.org.au/health-professionals

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: **Date:**	**Medical practitioner's name (and Medical Practice if required)** **Medical Practitioners Signature:** **Provider Number:** **Date:**	**Review Date:**

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

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:

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