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

STUDENT DETAILS

SCHOOL:	YEAR: FORM:	INSERT PHOTO HERE (If required)
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR 1:	
RELATIONSHIP TO STUDENT:	DOCTOR 2:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
NAME:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE YES ☐ NO ☐	
ADDRESS:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐	
RELATIONSHIP TO STUDENT:	**IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.**	
TELEPHONE: (W) (H) (M)	**STUDENT HAS A MEDICALERT BRACELET/PENDANT** YES ☐ NO ☐ IF YES PROVIDE DETAILS:	

SECTION A – HEALTH CARE PLANNING – TO BE COMPLETED BY PARENT/CARER

LIST SPECIFIC ALLERGENS AND MOST RECENT REACTIONS IN THE TABLE BELOW

MY CHILD IS ALLERGIC TO:	For each allergen provide specific information (e.g. grass – buffalo only).	Where applicable, please indicate your child's most recent reaction to the allergen (e.g. hay fever, hives, eczema).
Peanuts		
Tree Nuts		
Milk		
Eggs		
Soy Products		
Wheat Products		
Shellfish/Fish		
Insect Stings		
Medication		
Other/Unknown		

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME: SCHOOL: DOB:

SECTION B - DAILY MANAGEMENT

PROVIDE ADVICE THAT WOULD ASSIST IN THE MANAGEMENT OF YOUR CHILD'S ALLERGY.

SECTION C – EMERGENCY RESPONSE PLAN

SECTION D – STAFF TRAINING

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO MANAGE YOUR CHILD'S CONDITION OR NEEDS? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL).

A. FOR DAILY MANAGEMENT? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

B. IN AN EMERGENCY? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME: SCHOOL: DOB:

SECTION E: MEDICATION INFORMATION

	INSTRUCTIONS		
	MEDICATION 1	MEDICATION 2	MEDICATION 3
NAME OF MEDICATION			
EXPIRY DATE			
DOSE/FREQUENCY – MAY BE AS PER THE PHARMACIST'S LABEL			
ROUTE OF ADMINISTRATION			
DURATION (DATES)	FROM : TO:	FROM : TO:	FROM : TO:
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 F – AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, PARENT/CARER AND MEDICAL PRACTITIONER (IF REQUIRED).

THIS AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND MEDICAL PRACTITIONER AS SET OUT IN THE MINOR AND MODERATE ALLERGY MANAGEMENT AND EMERGENCY RESPONSE PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS.

PRINCIPAL: **DATE:**	**MEDICAL PRACTITIONER: (SIGNATURE REQUIRED)** **DATE:**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

OFFICE USE ONLY

IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐ DATE:

TYPE OF TRAINING:

NAME OF PERSONS TO BE TRAINED:

PRINCIPAL SIGNATURE:

COMPLETE AND ATTACH THE STUDENT HEALTH CARE SUMMARY FORM TO THE FRONT OF THIS DOCUMENT.