Sample: Individual Anaphylaxis Health Care Plan

STUDENT DETAILS – To be completed by parent/guardian		
School:	Year: Form:	INSERT PHOTO HERE
Student's Name:	Date of Birth:	
Address:	Male ☐ Female ☐	
PARENT/GUARDIAN CONTACT DETAILS	Teacher:	
1. Name:	**MEDICAL DETAILS**	
Address:	Doctor 1:	
Relationship to Student:	Doctor 2:	
Telephone: (W) (H) (M)	Medical Centre:	Telephone:
2. Name:	Hospital:	
Address:	Permission is given to seek medical attention for my child as required from the above medical centre. YES ☐ NO ☐	
Relationship to Student:	Do you have ambulance cover? YES ☐ NO ☐ **If there is a medical emergency parents/guardians are expected to cover the cost of an ambulance.**	
Telephone: (W) (H) (M)	Child has a medical bracelet/pendant. YES ☐ NO ☐ If yes, please provide details.	

SECTION A: STUDENT HEALTH CARE PLANNING – To be completed by parent/guardian

Please list specific allergens and most recent reactions in the table below:

MY CHILD IS ALLERGIC TO:	Please indicate which allergen(s) your child is allergic to.	Where applicable, please indicate your child's most recent reaction to the allergen *(e.g. anaphylaxis, hay fever, hives, eczema).*
Peanuts		
Tree nuts		
Cow's milk		
Eggs		
Soy products		
Wheat		
Shellfish		
Fish		
Sesame		
Insect Stings or Bites *(please specify if known)*		
Medication *(please specify medication(s) if known)*		
Other/Unknown *(please specify food(s) if known)*		

Name:	School:	DOB:

SECTION B: DAILY MANAGEMENT – To be completed in consultation with parent/guardian

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

SECTION C: STAFF TRAINING – To be completed by Principal

Is specific training for staff required? YES ☐ NO ☐	Date attended:
Type of training:	
Name of person(s) trained:	

SECTION D: EMERGENCY RESPONSE – As per the child's ASCIA Action Plan attached (this must be completed by the child's medical practitioner)

SECTION E: MEDICATION – To be completed by parent/guardian

	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:	From: to:
Route of administration (please tick appropriate box)	BY SELF ☐ REQUIRES ASSISTANCE ☐	BY SELF ☐ REQUIRES ASSISTANCE ☐	BY SELF ☐ REQUIRES ASSISTANCE ☐
Storage instructions (please tick appropriate box)	stored at school ☐ kept and managed by self ☐ refrigerate ☐ keep out of heat and sunlight ☐ other ☐	stored at school ☐ kept and managed by self ☐ refrigerate ☐ keep out of heat and sunlight ☐ other ☐	stored at school ☐ kept and managed by self ☐ refrigerate ☐ keep out of heat and sunlight ☐ other ☐

SECTION F: AGREEMENT BETWEEN THE SCHOOL PRINCIPAL AND PARENT/GUARDIAN – To be completed by Principal and Parent/Guardian

This agreement authorises the school staff to follow the advice of the child's parent/guardian and medical practitioner as set out in child's Individual Anaphylaxis Health Care Plan and the child's ASCIA Action 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:**	**Parent/Guardian:** **Date:**
Annual review date:	

A copy of the child's ASCIA Action Plan completed by the child's medical practitioner must be attached to this document.

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