Allergy care plan (including Anaphylaxis)

for education, child/care and community support services*

CONFIDENTIAL

To be completed by the DOCTOR and the PARENT/GUARDIAN and/or ADULT STUDENT/CLIENT.
This information is confidential and will be available only to supervising staff and emergency medical personnel.

Name of child/student/client _____ Date of birth _____
Family name (please print) First name (please print)

MedicAlert Number (if relevant) _____ Date for next review _____

☆ **NOTE: This care plan should be attached to the appropriate Australasian Society of Clinical Immunology and Allergy [ASCIA] Action Plan**
www.medeserv.com.au/ascia/aer/infobulletins/index.htm#anaph

First aid

If a child/student/client shows any of the described observable signs and symptoms, ASCIA Action Plan staff will administer first aid in accordance with Basic Emergency Life Support and including, as relevant, administration of prescribed adrenaline via EpiPen® or EpiPen® Jr as described on the attached ASCIA Action Plan.

If you anticipate this person will require anything other than this standard first aid response, please provide detailed written recommendations. Staff will use this plan to discuss with families how support can be provided in line with the capacities of their service.

NOTE: The child/student/client must be transported to hospital following an anaphylactic reaction and/or administration of adrenaline via an EpiPen® or EpiPen® Jr

MEDICATION INSTRUCTIONS (if medication is **other** than the adrenaline via EpiPen® or EpiPen® Jr as described on the attached ASCIA Action Plan) *(please print clearly)*	
Medication name *(include generic name)*	
Form *(eg liquid, tablet, capsule, cream)*	Route *(eg oral, inhaled, topical)*
Strength	Dose
Other instructions for administration	
Start/finish date *(if appropriate)* *from* *to*	

☆ **Additional information attached to this care plan**

- ☐ Australasian Society of Clinical Immunology and Allergy [ASCIA] Action Plan
  www.medeserv.com.au/ascia/aer/infobulletins/index.htm#anaph
- ☐ General information about this person's condition
- ☐ Other (please specify) _____

*** This plan has been developed for the following services/settings:**

- ☐ School/education
- ☐ Child/care
- ☐ Respite/accommodation
- ☐ Transport
- ☐ Outings/camps/holidays/aquatics
- ☐ Work
- ☐ Home
- ☐ Other *(please specify)*

AUTHORISATION AND RELEASE

Health professional _____ Professional role _____

Address _____

_____ Telephone _____

Signature _____ Date _____

I have read, understood and agreed with this plan and any attachments indicated above.
I approve the release of this information to supervising staff and emergency medical personnel.

Parent/guardian
or adult student/client _____ Signature _____ Date _____
Family name (please print) First name (please print)