Anaphylaxis (severe allergy) care plan

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 _____

Description of the condition

Possible observable signs and symptoms:

- ☐ Presence of known allergen
- ☐ Repeated vomiting
- ☐ Difficulty swallowing
- ☐ Swelling of lips, face or body
- ☐ Difficulty talking
- ☐ Loss of consciousness
- ☐ Generalised skin rash
- ☐ Cough
- ☐ Difficulty with noisy breathing (wheeze or stridor)

Known and suspected triggers: _____

First aid

If a child/student/client shows any of the above observable signs and symptoms, staff will administer first aid in accordance with Basic Emergency Life Support and including, as relevant, administration of prescribed adrenalin via EpiPen® or EpiPen® Jr as described on page 2 of this 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.

Additional information attached to this care plan

- ☐ *Medication authority* (if medication is other than the adrenalin via EpiPen® or EpiPen® Jr as described on page 2 of this plan)
- ☐ *Individual first aid plan* (Australasian Society of Clinical Immunology and Allergy [ASCIA] Action Plan)
- ☐ 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)