

# 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  | <input type="checkbox"/> |   |  |
| Tree Nuts  | <input type="checkbox"/> |   |  |
| Milk   | <input type="checkbox"/> |   |  |
| Eggs   | <input type="checkbox"/> |   |  |
| Soy Products   | <input type="checkbox"/> |   |  |
| Wheat Products   | <input type="checkbox"/> |   |  |
| Shellfish  | <input type="checkbox"/> |   |  |
| Fish   | <input type="checkbox"/> |   |  |
| Insect Stings or Bites (Please specify insect(s) if known) | <input type="checkbox"/> |   |  |
| Medication (Please specify which medication(s) if known)   | <input type="checkbox"/> |   |  |
| Other/Unknown(Please specify food(s) if known)             | <input type="checkbox"/> |   |  |

## Section B - Daily Management

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

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## 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 :<br>To:  |  | From :<br>To:  |  |  |  |
| Route of administration                               |  |  |  |  |  |  |
| Administration<br>Tick appropriate box                | By self<br>Requires assistance   | <input type="checkbox"/><br><input type="checkbox"/>   | By self<br>Requires assistance   | <input type="checkbox"/><br><input type="checkbox"/>   | By self<br>Requires assistance   | <input type="checkbox"/><br><input type="checkbox"/>   |
| Storage instructions<br>Tick appropriate box(es)      | Stored at school<br>Kept and managed by self<br>Refrigerate<br>Keep out of sunlight<br>Other | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | Stored at school<br>Kept and managed by self<br>Refrigerate<br>Keep out of sunlight<br>Other | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> | Stored at school<br>Kept and managed by self<br>Refrigerate<br>Keep out of sunlight<br>Other | <input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/><br><input type="checkbox"/> |

## Section D - Emergency Response

As per ASCIA action plan attached (This must be completed by your child's medical practitioner). Go to [http://www.allergy.org.au/images/stories/anaphylaxis/2014/ASCIA\\_Action\\_Plan\\_Allergic\\_Reactions\\_2014.pdf](http://www.allergy.org.au/images/stories/anaphylaxis/2014/ASCIA_Action_Plan_Allergic_Reactions_2014.pdf) for allergy action plans and further information.

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

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Year: \_\_\_\_\_ Form: \_\_\_\_\_ Teacher: \_\_\_\_\_

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**OFFICE USE ONLY**

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Date received: \_\_\_\_\_ Date uploaded on SIS: \_\_\_\_\_

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Is specific staff training required? Yes  No : \_\_\_\_\_ Type of training: \_\_\_\_\_

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Training service provider: \_\_\_\_\_

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Name of person/s to be trained: \_\_\_\_\_ Date of training: \_\_\_\_\_

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ASCIA Emergency Action Plans are regularly updated. To ensure you are using the most current documentation, go to:

[ASCIA Action Plan for Allergic Reactions \(personal\)](#)