FORM 4 – SEVERE ALLERGY/ANAPHYLAXIS
MANAGEMENT & EMERGENCY REPSONSE PLAN

60 Kelvin Street, Maylands 6051
Phone: (08) 9462 6700
Email: maylandspeninsula.ps@education.wa.edu.au

PLEASE RETURN THIS FORM TO ADMINISTRATION OFFICE

Student:		
Year: *	**Form:**	**Teacher:**
DOB:	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other**	

SECTION A – HEALTH CARE PLANNING – TO BE COMPLETED BY THE PARENT/CAREGIVER
(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. anaphylaxis, hay fever, hives, eczema)*
Peanuts	☐		
Tree Nuts	☐		
Milk	☐		
Eggs	☐		
Soy Products	☐		
Wheat Products	☐		
Shellfish	☐		
Fish	☐		
Insect Stings or Bites (*Please specify insect/s if known)*	☐		
Medication (*Please specify medicine/s if known)*	☐		
Other/Unknown *(Please specify food/s if known)*	☐		

SECTION B – DAILY MANAGEMENT

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

SECTION D - MEDICATION INSTRUCTIONS - *(NOTE - MEDICATION MUST BE PROVIDED BY PARENTS / CAREGIVER)*

	MEDICATION 1		**MEDICATION 2**		**MEDICATION 3**	
Name of Medication						
Expiry Date						
Dose / frequency *(As per pharmacist's label)*						
Duration Dates	**From:**		**From:**		**From:**	
	To:		**To:**		**To:**	
Route of Administration						
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 D – EMERGENCY RESPONSE – AS PER ANAPHYLAXIS (ASCIA) ACTION PLAN ATTACHED

MUST BE COMPLETED BY YOUR CHILDS MEDICAL PRACTIONER

SECTION E – AUTHORITY TO ACT

This severe allergy/anaphylaxis and emergency response plan authorises school staff school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a 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 Caregiver Name:	
Parent/Caregiver Signature:	**Date:**
Medical Practitioner Signature: *(If required at the principal's discretion)*	**Date:**

☐ **If you are completing this form online and are unable to sign this form, please check this box to confirm the above information is true and correct.**

OFFICE USE ONLY

Date received:	**Date uploaded on SIS:**
Is specific staff training required? **Yes** ☐ **No**: ☐	
Type of training:	**Training service provider:**
Name of person/s to be trained:	
Date of training:	

ASCIA Emergency Action Plans are regularly updated. To ensure you are using the most current documentation, go to the ASCIA website: https://www.allergy.org.au/health-professionals.

Submit

Maylands Peninsula PRIMARY SCHOOL "Learning together"

FORM 12 – RECORD OF HEALTH CARE SUPPORT ADMINISTRATION OF MEDICATION

60 Kelvin Street, Maylands 6051
Phone: (08) 9462 6700
Email: maylandspeninsula.ps@education.wa.edu.au

Student:

Year: *	**Form:**	**Teacher:**
DOB:	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other**	

RECORD OF HEALTH CARE SUPPORT / ADMINISTRATION OF MEDICATION

DATE	TIME	MEDICATION	DOSAGE	STAFF MEMBERS NAMES		SIGN / INITIALS	