

ARANMORE ALLERGY/ANAPHYLAXIS MANAGEMENT & EMERGENCY RESPONSE PLAN

NAME:	DATE OF BIRTH:	YEAR:
1. Health condition – Allergy		
Anaphylaxis	(Please tick)	
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		

specify insect(s) known)			
Medication (Please specify medicine(s) if known)			
Other (please specify food(s) if known)			

Section B – Daily Management

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

Section C – Medication Instructions

9. Authority to Act

This severe allergy/anaphylaxis 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/Caregiver Signature:

Medical practitioner's signature: (if required)

Date:

Date:

Review Date:

OFFICE USE ONLY

Date received:

Date uploaded to SEQTA:

Is specific staff training required? YES NO

Type of training

Training service provider:

Name of person's to be trained:

Date of training:

When completed, add to student file.