



Individual Anaphylaxis Management Plan



This plan is to be completed by the Principal or nominated Staff member based on the information provided by the student's medical practitioner as per the ASCIA Action Plan for Anaphylaxis provided by the Parent.

It is the responsibility of the Parent to:

- provide the school with a copy of the student's ASCIA Action Plan for Anaphylaxis containing the emergency response plan (**signed by the medical practitioner**) and any medication or autoinjector referenced in the plan.
- provide an up-to-date photo of the student (to be appended to this plan).
- inform the school if the child's medical condition, insofar as it relates to allergy and the potential for anaphylactic reaction, and if relevant provide an updated ASCIA Action Plan.

| | | | |
|--|--|-------------|--|
| School: | | Telephone: | |
| Student: | | | |
| Date of birth: | | Year level: | |
| Severely allergic to: | | | |
| Other health conditions: | | | |
| Medication at school: | | | |
| Other medication administered at home: | | | |

Emergency contact details (Parent)

Contact 1

| | | | |
|-----------------|--|--|----------------------------------|
| Name: | | | |
| Relationship: | | | |
| Contact numbers | | | List preferred order for contact |
| Home telephone: | | | |
| Work telephone: | | | |
| Mobile: | | | |
| Address: | | | |

Contact 2

| | | | |
|-----------------|--|--|----------------------------------|
| Name: | | | |
| Relationship: | | | |
| Contact numbers | | | List preferred order for contact |
| Home telephone: | | | |

| Emergency contact details (Parent) | | |
|------------------------------------|--|--|
| Work telephone: | | |
| Mobile: | | |
| Address: | | |

| Emergency Contact Details (Alternative) | |
|---|--------|
| Alternative contact 1 | |
| Name: | |
| Relationship: | |
| Home telephone: | |
| Work telephone: | |
| Mobile: | |
| Address: | |
| Alternative contact 2 | |
| Name: | |
| Relationship: | |
| Home telephone: | |
| Work telephone: | |
| Mobile: | |
| Address: | |
| Essential Medical Information | |
| Medical practitioner name: | Phone: |
| Emergency care to be provided at school: | |
| Storage location for autoinjector device: | |
| Date of expiry of autoinjector: | |

Environment

To be completed by the Principal or nominated Staff member. Please consider each environment/area (on or off school site) the student will be in for the year, e.g., classrooms, school yards, specialist teaching areas, excursions, camps.

| Name of environment/area: | | | |
|---------------------------|---------------------------------------|--------------------|------------------|
| Risk Identified | Actions required to minimise the risk | Who is responsible | Completion date? |
| | | | |
| | | | |
| | | | |
| | | | |

| Name of environment/area: | | | |
|---------------------------|---------------------------------------|--------------------|------------------|
| Risk Identified | Actions required to minimise the risk | Who is responsible | Completion date? |
| | | | |
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| Name of environment/area: | | | |
|---------------------------|---------------------------------------|--------------------|------------------|
| Risk Identified | Actions required to minimise the risk | Who is responsible | Completion date? |
| | | | |
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| Name of environment/area: | | | |
|---------------------------|---------------------------------------|--------------------|------------------|
| Risk Identified | Actions required to minimise the risk | Who is responsible | Completion date? |
| | | | |
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| | | | |

| Name of environment/area: | | | |
|---------------------------|---------------------------------------|--------------------|------------------|
| Risk Identified | Actions required to minimise the risk | Who is responsible | Completion date? |
| | | | |
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Agreement/Signatures

This **Individual Anaphylaxis Management Plan** has been developed with my knowledge and input based upon health advice received from the student's medical practitioner.

Parent or Mature minor

| | |
|---------------------------------|--|
| Name of Parent or Mature minor* | |
| Signature | |
| Date | |

Principal

| | |
|-------------------|--|
| Name of Principal | |
| Signature | |
| Date | |

| | |
|---------------------|--------------------------------|
| Approval authority | Director, Education Excellence |
| Approval date | 22 April 2025 |
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