Outside School Hours Care Enrolment Form

Date received
___/___/_____

Guthrie St. Shepparton
PO Box 1310
SHEPPARTON VIC 3630

Phone: 5821 1944
O.S.H.C. 0409 132332
www.guthriestps.vic.edu.au

Child's Personal Details

Surname: _____

First Name: _____ Second Name: _____

Preferred Name: _____ Birth Date: ____/____/____

Address: _____ Post Code: _____

Name of School Child Attends: _____ Year Level: _____

Male: ____ Female: ____ Language spoken at home: _____

In which country was the child born?: Australia ☐ Other: _____

Is the child of Aboriginal or Torres Strait islander origin? No ____ Yes, Aboriginal ____

Yes, Torres Strait Islander ____ or Yes, Both Aboriginal & Torres Strait Islander ____

Child's Religion: _____

Any cultural/religious considerations required?: _____

_____

_____

Medical Details Does your child have Asthma? ____ Anaphylaxis? ____ Epilepsy? ____

If yes, please complete the attached Plan/s.

Does your child have any other Medical Conditions / Allergies etc?: ____

If yes, please complete the attached Medical Conditions form.

Does the child have a developmental delay or disability including intellectual, sensory or physical impairment? Yes ____ No ____

Immunisation Certificate Status: Complete ____ Incomplete ____

It is a legal requirement that parent's/guardians provide an approved Immunisation Certificate. Please attach a copy to this Enrolment.

Does your child have any dietary /additional requirements? ____ If yes, please list.

_____

_____

Child's Doctor: _____ Phone no: _____

Address: _____

Medicare No: _____

Ambulance Subscription: Yes Membership No: _____ No

For Childcare Benefits please provide CRN No's

Parent CRN: ☐ _____ Child CRN: ☐ _____

Bookings: Casual: Yes ☐ Permanent: Yes ☐ If permanent, note days and times

Monday From: _____ to _____ Tuesday From: _____ to _____

Wednesday From: _____ to _____ Thursday From: _____ to _____

Friday From: _____ to _____

Siblings in the O.S.H.C. Program

Name: _____ Yr Level: ____

Name: _____ Yr Level: ____

Name: _____ Yr Level: ____

Outside School Hours Care - PRIVACY NOTICE

Information about the Enrolment Form.
Please Read This Notice Before Completing The Enrolment Form.

This confidential enrolment form asks for personal information about your child as well as family members and others that provide care for your child. The main purpose for collecting this information is so that Guthrie Street Primary School OSHC can register your child and allocate staff and resources to provide for their educational and support needs. All staff at Guthrie Street Primary School OSHC and the Department of Education & Training are required by law to protect the information provided by this enrolment form.

Health information is asked for so that staff at Guthrie Street Primary School OSHC can properly care for your child. This includes information about any medical condition or disability your child may have, medication your child may rely on while at school, any known allergies and contact details of your child's doctor. Guthrie Street Primary School OSHC depends on you to provide all relevant health information because withholding some health information may put your child's health at risk.

Guthrie Street Primary School OSHC requires information about all parents, guardians or carers so that we can take account of family arrangements. Family Court Orders setting out any access restrictions and parenting plans should be made available to Guthrie Street Primary School OSHC. Please tell us as soon as possible about any changes to these arrangements. Please do not hesitate to contact the Co-ordinator, Guthrie Street Primary School OSHC, if you would like to discuss, in strict confidence, any matters relating to family arrangements.

Emergency Contacts
These are people that Guthrie Street Primary School OSHC may need to contact in an emergency. Please ensure that the people named are aware that they have been nominated as emergency contacts and agree to their details being provided to Guthrie Street Primary School OSHC.

Student Background Information
This includes information about a person's country of birth, aboriginality, language spoken at home and parent occupation. This information is collected so that Guthrie Street Primary School OSHC receives appropriate resource allocations for their students. It is also used by the Department to plan for future educational needs in Victoria. Some information is sent to Commonwealth government agencies for monitoring, planning and resource allocation. All of this information is kept strictly confidential and the Department will not otherwise disclose the information to others without your consent or as required by law.

Immunisation status
This assists Guthrie Street Primary School OSHC in managing health risks for children. This information may also be passed to the Department of Human Services to assess immunisation rates in Victoria. Information sent to the Department of Human Services is aggregate data so no individual is identified.

UPDATING YOUR CHILD'S RECORDS
Please let Guthrie Street Primary School OSHC know if any information needs to be changed by sending updated information to the school office.

ACCESS TO YOUR CHILD'S RECORD HELD BY OSHC
In most circumstances you can access your child's records. Please contact the Co-ordinator to arrange this.
Sometimes access to certain information, such as information provided by someone else, may require a Freedom of Information request. We will advise you if this is required and tell you how you can do this.

If you have any concerns about the confidentiality of this information please contact the Co-ordinator. Guthrie Street Primary School OSHC can also provide you with more detailed information about privacy policies that govern the collection and use of information requested on this form. This form is available on request.

VICTORIA State Government | Education and Training

Details of Parent/Guardian

Adult A (parent/guardian) Relationship to child: _____

Name:_____ D.O.B. _____

In which country was Adult A born?: Australia ☐ Other: _____

Home: _____ Work: _____ Mobile: _____

Address: As per child ☐ or : _____

Name and address of Employment: _____

_____

Email address: _____

Adult B (parent/guardian) Relationship to child: _____

Name: _____ D.O.B. _____

In which country was Adult B born?: Australia ☐ Other: _____

Home: _____ Work: _____ Mobile: _____

Address: As per child ☐ or : _____

Name and address of Employment: _____

_____

Email address: _____

EMERGENCY CONTACTS & AUTHORISED NOMINEES

In case of accident or injury, trauma or illness when parents/guardians are not available, the persons below will be contacted to pick up the child and take care of them.

- In the event that the child is not collected from the children's service and the parent or guardians cannot be contacted, this list will also be used to arrange someone to collect the child.
- Any person who is authorised to consent to medical treatment of, or to authorise administration of medication to, the child
- Any person who is authorised to authorise an educator to take the child outside the education and care service premises.

Name	Phone (H)	Phone (M)	Relationship to child

PG Rated Movies
Throughout the OSHC Program movies rated G & PG will be available for children to watch. We require parental consent for children to watch PG rated movies.

I give /do not give permission for my child to watch PG Rated Movies in the OSHC Program.

Signatures of Parents/Guardians/Carers: **Date: ___/___/_____**

_____ _____

Sunscreen Authorisation
I give/do not give permission for my child to have sunscreen applied as per OSHC Sunsmart Policy.

Signatures of Parents/Guardians/Carers: **Date: ___/___/_____**

_____ _____

Local Excursions

I give / do not give permission for my child to attend excursions organised by the OSHC Program.

Signatures of Parents/Guardians/Carers: **Date: ___/___/_____**

_____ _____

Emergency Assistance / Medication Administration Authorisation

I authorise the co-ordinator/supervisor of Outside School Hours Care where it is impractical to communicate with me, to seek medical treatment for my child:

- ☐ from a registered medical practitioner
- ☐ from a hospital service
- ☐ from an ambulance service
- ☐ transportation of my child by ambulance

I authorise the co-ordinator/supervisor of Outside School Hours Care to administer any relevant medications of pre-existing or existing medical conditions.

Signatures of Parents/Guardians/Carers: **Date: ___/___/_____**

_____ _____

I certify that the information contained within this form is correct.

Parent/Guardian: _____ Signature: _____

(please print name)

Parent/Guardian: _____ Signature: _____

(please print name) Date: ____/____/_____

OSHC (Outside School Hours Care)

Photographing, Filming and Recording children

During the year there are many occasions and events where staff in OSHC may photograph, film or record children participating in OSHC activities and events. We do this for many reasons including celebrating children participation and achievement, showcasing particular excursions, events etc, communication with our parents and school community in newsletters and social media.

This notice applies to photographs, video or recordings of children that are collected, used and disclosed by OSHC. We ask that any parents/carers or other members of our school community photographing, filming or recording students at OSHC events do so in a respectful and safe manner and that any photos, video or recordings of children are not publicly posted (eg to a social media account) without the permission of the relevant parent/carer.

This agreement is for the duration of your child's attendance at GSPS OSHC program. If your personal circumstances change please advise OSHC with your updated information.

If you do not understand any aspect of this notice, or you would like to talk about any concerns you have, please contact Jo Wilson 0409 132 332 or Brendan Bicknell on 58211944.

A. Use or disclosure within the school community and locations that are publicly accessible

Unless you tell us otherwise below, images of your child may be used by OSHC within the school community and in public locations, as described below.

Photographs, video or recordings of children may be used in any of the following ways:

- in the school's communication via emails, apps, Compass etc
- for display in school classrooms, on noticeboards etc
- School website and social media eg school accounts on Youtube, twitter, Facebook etc
- In local published media Win News, Shepp News etc
- School advertising eg pamphlets, brochures, advertising billboards etc
- in the school's newsletter

Your child may be identified by name in the publications mentioned above.

Privacy

Photographs, video and recordings of a person that may be capable of identifying the person may constitute a collection of 'personal information' under Victorian privacy law. This means that any images of your child taken by OSHC may constitute a collection of your child's personal information. OSHC is part of the Department of Education and Training (**the Department**). The Department values the privacy of every person and must comply with the *Privacy and Data Protection Act 2014* (Vic) when collecting and managing all personal information. For further information see ***OSHC Privacy Policy*** (http://www.education.vic.gov.au/Pages/schoolsprivacypolicy.aspx).

Ownership and Reproduction

Copyright of the images will be wholly owned by OSHC. This means that OSHC may use the images in the ways described in this form without notifying, acknowledging or compensating you or your child.

Opt Out

OSHC understands that parents and carers have the right to withhold permission for OSHC to use photographs, video or recordings of your child (apart from circumstances where OSHC is not required to seek consent.

If you have read this notice and are comfortable with the school using photos, video or recordings of your child as described above, you do not need to take any further action.

However, if you have decided that you **do not** want images of your child to be collected or used by OSHC, **please complete the form below** and return it to OSHC. Please note that it may not be possible for OSHC to amend past publications or to withdraw images that are already in the public domain.

I have read this form and I **do not consent** to OSHC using photos, video or recordings of my child (named below)

Note- Only fill in the box below if you DO NOT consent to the school using your child's photographic images.

If you agree to the school using photographic images no further action is required

Name of Student	
Name of parent/carer	
Signature	
Date	____ / ____ / _____

MEDICAL CONDITIONS NAME: _____ CLASS: _____

(More copies of the other medical condition forms are available on request from the school.)

Does the student have any other medical condition? (tick)					☐ Yes	☐ No
If yes, please specify:						
Symptoms:						
If my child displays any of the symptoms above please: (tick)						
Inform Doctor	☐ Yes	☐ No	Inform Emergency Contact		☐ Yes	☐ No
Administer Medication	☐ Yes	☐ No	Other Medical Action		☐ Yes	☐ No
If yes, please specify:						
Does the student take medication for the above medical conditions? (tick)					☐ Yes	☐ No
Name of medication taken:						
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)					☐ Preventative	☐ Response
Indicate the usual dosage of medication taken:			**Indicate how frequently the medication is taken:**			
Medication is usually administered by: (tick)	☐ Student	☐ Nurse	☐ Teacher	☐ Other		
Is a reminder required for the student to take their medication? (tick)					☐ Yes	☐ No
Medication is stored: (tick)	☐ with Student	☐with Nurse	☐ Fridge in Staff Room	☐ Elsewhere		
What is the Poison Rating of the medication being taken?						

OTHER MEDICAL CONDITIONS

(More copies of the other medical condition forms are available on request from the school.)

Does the student have any other medical condition? (tick)					☐ Yes	☐ No
If yes, please specify:						
Symptoms:						
If my child displays any of the symptoms above please: (tick)						
Inform Doctor	☐ Yes	☐ No	Inform Emergency Contact		☐ Yes	☐ No
Administer Medication	☐ Yes	☐ No	Other Medical Action		☐ Yes	☐ No
If yes, please specify:						
Does the student take medication for the above medical conditions? (tick)					☐ Yes	☐ No
Name of medication taken:						
Is the medication taken regularly by the student (preventive) or only in response to symptoms? (tick)					☐ Preventative	☐ Response
Indicate the usual dosage of medication taken:			**Indicate how frequently the medication is taken:**			
Medication is usually administered by: (tick)	☐ Student	☐ Nurse	☐ Teacher	☐ Other		
Is a reminder required for the student to take their medication? (tick)					☐ Yes	☐ No
Medication is stored: (tick)	☐ with Student	☐with Nurse	☐ Fridge in Staff Room	☐ Elsewhere		
What is the Poison Rating of the medication being taken?						

Student Access Restriction Details (for all separated parents)

Is the student at risk? (tick) Yes ☐ No ☐

Is there an Access Alert for the student? (tick) Yes ☐ No ☐

Access Type: (tick) Court Order ☐ Family Law Order ☐ Restraining Order ☐ Other ☐

Parental Responsibility: Shared ☐ Sole ☐

Mother's/Father's name: _____ (eg. Alternate Family)

Address: _____ Phone no: _____

Does your child have contact with the mother/father eg. Alternate family Yes ☐ No ☐

Is the Alternative Family to receive Academic Reports? Yes ☐ No ☐

Please describe any Access Restrictions/custody arrangements and attach any custody orders currently in place. _____

_____

_____

_____

I, _____ confirm that the Student Access Restriction Details above is correct
(print name)
and I will provide the OSHC Co-ordinator with any further changes or additions if and when applicable.

Signed: _____ Dated: ___/___/20____

OFFICE USE ONLY

Current custody document placed on student file ☐ Yes ☐ No

Date received ___/___/_____

Activity Restrictions Details

Is there an Activity Alert for the student? (eg. sport, music, drama) (tick) ☐ Yes ☐ No

If Yes, then describe the Activity Restriction:

_____

_____

_____

_____

_____

STUDENT CODE OF CONDUCT

The Guthrie Street Primary School Outside School Hours Care program has established the following guidelines to ensure all children can enjoy activities in a safe and caring environment.

Guidelines (as per Guthrie Street Primary School Student Code of Conduct)

- Move and play safely
- Care for yourself, others and property.
- Resolve problems calmly, sensibly and fairly.
- Respect others through your speech and manners.
- Work and play as well as you can and allow others to do the same.

Children are responsible for their own actions. The consequences for not following these guidelines are outlined below –

- **First Offence** – The staff member who is working with the child will remove the child from the activity they are participating in. The child will be given 5 minutes to re-think their behaviour. At the conclusion of the 5 minutes the staff member will discuss with the child their actions and how they are outside the Code of Conduct Guidelines of Outside School Hours Care. The child will then be given the opportunity to re-enter the activity they were participating in.
- **Second Offence** – the Outside School Hours Care Coordinator will deal with the child's second offence. The child will be given 10 minutes to re-think their behaviour. At the conclusion of the 10 minutes the Coordinator will discuss with the child their actions and how they are outside the Code of Conduct Guidelines of Outside School Hours Care. The child will then be given the opportunity to re-enter the activity they were participating in.
- **Third Offence** - the Principal Class of the school will deal with the child's third offence. If it is the child's first time at the third offence level the child will remain with the Principal Class member until their parents arrive to collect them from Outside School Hours Care. Upon collection of the child the Principal Class member will discuss with the parent/s and the child the behaviours that were outside the Code of Conduct Guidelines of Outside School Hours Care. The parent and the child will then be reminded that the next time the child reaches the third offence level the parents will be contacted and expected to collect the child immediately.

Please Note –

1) Offences do not carry over from day to day.
2) If a breach of the guidelines is extremely serious the step by step process may be by-passed, with the parents contacted and expected to collect their child immediately
3) Continued poor behaviour could see a child's position in Outside School Hours Care withdrawn.

Outside School Hours Care Behaviour Agreement:

I have discussed with my child the need for acceptable behaviour at all times and the need to pay attention, and follow the Co-ordinator/ Team Leaders of Outside School Hours Care instructions and directions.

Students are required to follow Student Code of conduct and Parents are required to collect children when these behaviours are considered or progress to an offence.

I _____ **(print name)** will collect my child immediately if they do not follow the Student Code Conduct.

Signature: _____ Date: ____/____/20____

Epilepsy: Know me, Support me.

Insert jpeg image here

Epilepsy Management Plan

Name of person living with epilepsy:		
Date of birth:	Date plan written:	Date to review:

1. General information

Medication records located:
Seizure records located:
General support needs document located:
Epilepsy diagnosis (if known):

2. Has emergency epilepsy medication been prescribed? **Yes** ☒ **No** ☐

If yes, the medication authority or emergency medication plan must be attached and followed*, if you are specifically trained.

These documents are located:

3. My seizures are triggered by: (if not known, write no known triggers)

4. Changes in my behaviour that may indicate a seizure could occur:

(For example pacing, sad, irritability, poor appetite, usually very mobile but now sitting quietly)

5. My seizure description and seizure support needs:

(Complete a separate row for each type of seizure – use brief, concise language to describe each seizure type.)

Description of seizure (Make sure you describe what the person looks like before, during and after and if they typically occur in a cluster)	**Typical duration of seizure** (seconds/ minutes)	**Usual frequency of seizure** (state in terms of seizures per month, per year or per day)	**Is emergency medication prescribed for this type of seizure?**	**When to call an ambulance** If you are trained in emergency medication administration* refer to the emergency medication plan and the medication authority
			Yes ☐ No ☐	If you are untrained in emergency medication, call ambulance when:

6. How I want to be supported during a seizure:

Specify the support needed during each of the different seizure types.

(If you are ever in doubt about my health during or after the seizure, call an ambulance)

7. My specific post-seizure support:

State how a support person would know when I have regained my usual awareness and how long it typically takes for me to fully recover. How I want to be supported. Describe what my post seizure behaviour may look like.

8. My risk/safety alerts:

For example bathing, swimming, use of helmet, mobility following seizure.

Risk	What will reduce this risk for me?

9. Do I need additional overnight support? **Yes** ☐ **No** ☐

If 'yes' describe:

This plan has been co-ordinated by:

Name:	Organisation (if any):
Telephone numbers:	
Association with person: (For example treating doctor, parent, key worker in group home, case manager)	
Client/parent/guardian signature (if under age):	

Endorsement by treating doctor:

Your doctor's name:
Telephone:

Doctor's signature:	Insert jpeg here	Date:

Australia wide epilepsy help line 1300 852 853

epilepsy foundation

OSHC - Individual Asthma Information Form

STUDENT NAME:- _____

My Triggers are:- (please circle)

- Viral illness (eg Cold)
- Change in weather
- Change in seasons
- Cold air
- Pollens
- Dust
- Allergies _____
- Other

  _____

  _____

  _____

My Asthma symptoms are:- (please circle)

- Shortness of Breath
- Cough
- Wheeze
- Other

  _____

  _____

  _____

Other important information about my asthma (eg: medications taken at home each day)

_____

_____

_____

FOR USE WITH PUFFER AND SPACER

PHOTO

ASTHMA ACTION PLAN

VICTORIAN SCHOOLS

ASTHMA AUSTRALIA

Student's name: _____

DOB: _____

Confirmed triggers: _____

_____

_____

- ☐ Child can self-administer if well enough
- ☐ Child needs to pre-medicate prior to exercise
- ☐ Face mask needed with spacer

ALWAYS give adrenaline autoinjector FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms.

Adrenaline autoinjector prescribed: ☐ Y ☐ N Type of adrenaline autoinjector: _____

ASTHMA FIRST AID

For Severe or Life-Threatening signs and symptoms, call for emergency assistance immediately on Triple Zero "000"
Mild to moderate symptoms do not always present before severe or life-threatening symptoms

1. **Sit the person upright**
   Stay with the person and be calm and reassuring
2. **Give____separate puffs of Airomir, Asmol or Ventolin**
   Shake the puffer before each puff
   Puff 1 puff into the spacer at a time
   Take 4 breaths from spacer between each puff
3. **Wait 4 minutes**
   If there is no improvement, repeat step 2
4. **If there is still no improvement call emergency assistance**
   Dial Triple Zero "000"
   Say 'ambulance' and that someone is having an asthma attack
   Keep giving____puffs every 4 minutes until emergency assistance arrives

Commence CPR at any time if person is unresponsive and not breathing normally.

Blue/grey reliever medication is unlikely to harm, even if the person does not have asthma.

SIGNS AND SYMPTOMS	MILD TO MODERATE	SEVERE	LIFE-THREATENING
	• Minor difficulty breathing • May have a cough • May have a wheeze • Other signs to look for:	• Cannot speak a full sentence • Sitting hunched forward • Tugging in of skin over chest/throat • May have a cough or wheeze • Obvious difficulty breathing • Lethargic • Sore tummy (young children)	• Unable to speak or 1–2 words • Collapsed/exhausted • Gasping for breath • May no longer have a cough or wheeze • Drowsy/confused/ unconscious • Skin discolouration (blue lips)

Emergency contact name: _____

Work ph: _____

Home ph: _____

Mobile ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

Signed: _____ I hereby authorise medications specified on this plan to be administered according to the plan

Date prepared: _____

Date of next review: _____

- Assemble spacer.
- Remove cap from puffer.
- Shake puffer well.
- Attach puffer to end of spacer.
- Place mouthpiece of spacer in mouth and ensure lips seal around it.
- Breathe out gently into the spacer.
- Press down on puffer canister once to fire medication into spacer.
- Breathe in and out normally for 4 breaths (keeping your mouth on the spacer).

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by medical or nurse practitioner:

_____

I hereby authorise medications specified on this plan to be administered according to the plan

Signed:

_____

Date: _____

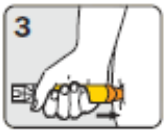
Action Plan due for review – date:

_____

How to give EpiPen® adrenaline (epinephrine) autoinjectors

Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE

Hold leg still and PLACE ORANGE END against outer mid-thigh (with or without clothing)



PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds

REMOVE EpiPen®

EpiPen® is prescribed for children over 20kg and adults. EpiPen®Jr is prescribed for children 10-20kg

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Locate adrenaline autoinjector
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk

- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**

2 Give adrenaline autoinjector

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline doses may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation

If in doubt give adrenaline autoinjector

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS give adrenaline autoinjector FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

- *If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre.*
- *Continue to follow this action plan for the person with the allergic reaction.*

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australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by medical or nurse practitioner:

_____

I hereby authorise medications specified on this plan to be administered according to the plan

Signed:

_____

Date: _____

Action Plan due for review – date:

_____

Note: This ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens.

For people with severe allergies (and at risk of anaphylaxis) there are red ASCIA Action Plans for Anaphylaxis (brand specific or generic versions) for use with adrenaline (epinephrine) autoinjectors.

Instructions are on the device label.

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 10-20kg.

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of anaphylaxis for insect allergy)

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk

- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**

2 Give adrenaline (epinephrine) autoinjector if available

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Transfer person to hospital for at least 4 hours of observation

If in doubt give adrenaline autoinjector

Commence CPR at any time if person is unresponsive and not breathing normally

ALWAYS give adrenaline autoinjector FIRST if available, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

- *If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre.*
- *Continue to follow this action plan for the person with the allergic reaction.*