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| --- | --- | --- | --- |
| **A group of children holding hands  Description automatically generated Individualised anaphylaxis care plan** | | | |
| **SECTION A – Child’s details** – This section is to be completed by parent/guardian | | | |
| Name: | | Gender: | Date of birth: |
| Address: | | Room: | |
| Nominated supervisor:  Teacher’s Name:  Educator’s Name: | |
| **Parent/guardian contact details** | | **Medical contact details** | |
| Name:  Relationship to child:  Phone: | | Doctor:  Medical Centre/Practice name:  Phone: | |
| Name:  Relationship to child:  Phone: | |
| **SECTION B – Child health care planning –** This section is to be completed by parent/guardian | | | |
| Please tick what your child is allergic to below: | | | |
| Milk (dairy) | Tree nuts (please specify specific nut/s)  Almond  Brazil nut  Cashew  Hazelnut  Macadamia  Pecan  Pine nut  Pistachio  Walnut  All tree nuts should be avoided while at the CEC service | | |
| Peanut |
| Egg |
| Soy |
| Wheat |
| Crustaceans (Shellfish) |
| Molluscs |
| Fish |
| Sesame |
| Lupin |
| Other foods *(please specify):* |
| Insect stings or bites *(please specify if known):* | | | |
| Medication *(please specify if known):* | | | |
| Latex | | | |
| Other/Unknown *(please specify if known):* | | | |

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| --- | --- | --- | --- | --- |
| Child’s Name: Chelsea Heights Kindergarten DOB: | | | | |
| **SECTION C – Daily management –** This section is to be completed in consultation with parent/guardian | | | | |
| List strategies that would minimise the risk of exposure to known allergens  *(expand section as required if not completed electronically)* | | | | |
| **section D – Medication –** This section is to be completed by parent/guardian | | | | |
|  | **Medication 1** | | **Medication 2** | **Medication 3** |
| Name of medication  (include adrenaline injectors) |  | |  |  |
| Expiry date |  | |  |  |
| Where is the medication stored?  Note: Adrenaline injectors must be stored in an unlocked location at room temperature  (please tick all that are appropriate) | Stored at CHK  Where:  Kept and managed  by self (if OSHC)  Where:    Other: | | Stored at CHK  Where:  Kept and managed  by self (if OSHC)  Where:  Other: | Stored at CHK  Where:  Kept and managed  by self (if OSHC)  Where:  Other: |
| **section E – ASCIA Action Plan –** This section is to be completed by parent/guardian | | | | |
| Date ASCIA Action Plan completed by doctor or nurse practitioner:  Date of next review:  A copy of the child’s ASCIA Action Plan completed by the child’s doctor or nurse practitioner must be attached to this document. | | | | |
| **SECTION F – Agreement –** This section is to be completed by the child’s teacher and parent/guardian | | | | |
| This agreement authorises CHK staff to follow the advice of the child’s parent/guardian as set out in this child’s individualised anaphylaxis care plan. It is valid for one year or until the parent/guardian advises the CHK service of a  change in their child’s health care requirements. | | | | |
| **CHK teacher’s name:**  **CHK educator’s name:**  **Date:** | | **Parent/guardian name:**  **Signature**  **Date:** | | |
| **Review date:** | | | | |