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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 managedby self (if OSHC)Where: [ ]  Other: | [ ]  Stored at CHKWhere:[ ]  Kept and managedby self (if OSHC)Where: [ ]  Other: | [ ]  Stored at CHKWhere:[ ]  Kept and managedby 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:** |