THE FRIENDS' SCHOOL

STUDENT ALLERGY / ANAPHYLAXIS INFORMATION & MANAGEMENT PLAN

Student's Full Name		
Class / Tutor Group		
Date of Birth		
Form Sections A & B Any person reporting an allergy must complete both sections A and B. If the person answers "yes" to any question in section B then the person and the school must prepare an Individual Anaphylaxis Management Plan & Action Plan by completing pages 2 and 3 of this form.	**Section A**	Does this student have an allergy? ☐ No ☐ Yes He/she is allergic to _____
	Section B	Has it involved hospitalisation? ☐ No ☐ Yes Is it life threatening? ☐ No ☐ Yes Has it been called anaphylaxis? ☐ No ☐ Yes Has the student been prescribed an EpiPen ☐ No ☐ Yes

Signature

Signing this form - to sign this form you must be either be:
an independent or adult student; or
the parent or guardian or other person who has care and control of the student.

I certify that the information provided in this form is correct.

Signed: _____ **Date:**

Day Month Year

✓ *Tick one box below*

Signed by: ☐ Parent ☐ Guardian

__ __ / __ __ / __ __ __ __

Personal Information Protection Statement

Personal information and medical details are collected from you so that school staff can develop a medical action plan and provide support for the student's medical condition. Personal information may be disclosed to staff, health practitioners, allied health professionals, etc to support student health requirements. Information may also be provided to other organisations where it is required by law.

Personal information will be managed in accordance with the Privacy Policy, a copy of which can be made available to you on request (contact the Business Manager's Office).

Office Use: Enter this information into the student record.

☐ Yes *(Entered into student record)* Date: ……

INDIVIDUAL ANAPHYLAXIS MANAGEMENT PLAN

Important Note: You should only proceed beyond this point if the person completing the form has answered "yes" to any of the questions detailed in Section B on page 1(the preceding page) of the form.

Student's name:	Date of birth:
Current Teacher / Tutor:	Year:
Severely allergic to:	
Other health conditions:	
Medication at school:	
Parent/carer contact:	
First parent/carer	***Second parent/carer***
Name:	*Name:*
Relationship:	*Relationship:*
Home phone:	*Home phone:*
Work phone:	*Work phone:*
Mobile:	*Mobile:*
Address:	*Address:*
Other emergency contacts (if parent/carer not available):	
Medical practitioner contact:	
Date Action Plan Prepared:	

This Anaphylaxis Management Plan (and Action Plan) has been developed with my knowledge and participation and will be reviewed on: I agree that the Action Plan can be displayed in the Staff Room / School Office / Classroom *(please circle as appropriate)*	Date:
Parent(s) signature:	Date:
Head of School signature:	Date:

GENERIC/INDIVIDUAL STRATEGIES FOR AVOIDING ALLERGENS

Student's name	Date of birth
Severe allergies	
Other known allergies	
Asthmatic? ☐ Yes* ☐ No	*High risk for severe reaction

RISK	STRATEGY	WHO
	○ ○ ○	○
	○ ○ ○	○
	○ ○ ○	○
	○ ○ ○	○