Wellers Hill SACCS

CHILD'S PHOTO

MEDICAL MANAGEMENT PLAN - ANAPHYLAXIS

Child's name …… Age: ……. D.O.B. ……

Allergy:……..

POSSIBLE SIGNS & SYMPTOMS: ……

……

WHAT TO DO IF A REACTION OCCURS:

1. Ask someone to call an ambulance on **000**
2. Administer an Epi-pen according to written instructions
3. Notify parent/guardian

AUTHORISATION FOR MANAGEMENT PLAN TO BE FOLLOWED:

I/we…….. being the parent/guardian of…… hereby authorise an educator/staff member to administer allergy medication/injection to my child, if necessary.

Medication provided by me, the parent, will be in accordance with OSHC service policy and procedures and shall be kept at the OSHC service.

Parent signature: …… Date: ……

Coordinator signature: …… Date: ……

PARENTAL AUTHORISATION TO ADMINISTER AN ADRENALINE AUTO INJECTOR

I/we……..being the parent/guardian of ……

hereby authorise OSHC staff to administer an adrenaline auto injection, should my child come into contact with any

(please specifiy allergens) ……

And/or display symptoms as specified in my child's Medical Management Plan.

This is in accordance with service policies and family enrolment procedures

Parent/guardian name: …… Signature: …… Date: ……..

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