



ACTION PLAN FOR STUDENTS WITH AN ALLERGY

(not anaphylactic) - PROVIDED BY PARENTS

Child's Name: _____ DOB: _____

Location of child's medication (if applicable): _____

Doctor's name: _____ Phone: _____

Family emergency contact name: _____

Mobile: _____ Work: _____ Home: _____

PLAN

Known allergens:

Treatment:

Mild to moderate allergic reaction:

Signs:

Treatment:

Severe allergic reaction:

Signs:

Treatment:

Does your child know how to self-administer required medication and have permission to do so under supervision of an OSHC staff member? Yes No Signature: _____

In an emergency requiring medical attention I authorise OSHC to contact the doctor listed above and/or call an ambulance.

Name: _____ Signature: _____ Date: _____

I have discussed the above information with my doctor and authorise OSHC to follow what I have stated in the above action plan.

Name: _____ Signature: _____ Date: _____