Severe Allergies – Information from the doctor

This form is to be completed by the doctor. Information provided will be used for the development of the student’s individual health care plan at school.

Please provide, completed and signed, the appropriate ASCIA Action Plan for Anaphylaxis for this patient outlining the emergency response for anaphylaxis. The plans can be accessed from the ASCIA website at http://www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-action-plan-for-anaphylaxis

Please complete all parts of the plan so they can bring it to school for use as the schools emergency response plan.

The additional information requested below will further assist the school in the development of the student’s individual health care plan.

Name of patient: ______________________________________________________

This patient has:

- mild asthma □ □ moderate asthma
- severe asthma: □ □ no history of asthma

Other relevant health conditions: ____________________________________________

_______________________________________________________________________

Conditions known to you that may impact on the student’s ability to understand the nature of their anaphylaxis and the risk that it poses to them:

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

This has been discussed by you with the patient/his or her parents

Yes □ No □
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Other information or details you believe are important in managing the severe allergy at school and during activities conducted under the auspices of the school:
____________________________________________________
____________________________________________________
____________________________________________________
Please telephone the school on ______________________ and speak to the school principal if you require further information.

Doctor: ______________________________________________
Address: ______________________________________________
Phone: ________________________________________________
Fax: __________________________________________________
Email: ________________________________________________

Signature (Doctor): _________________________________

Date: _____/____/______

Signature (Principal) _________________________________
Name of Principal _________________________________

Date: _____/____/______

I ____________________________ consent to this information being provided for the school’s use so they can develop an individual health care plan for my child ____________________________ at school.

Parent/carer signature: ____________________________ Date _____/____/____