EMERGENCY ACTION PLAN

*****IMPORTANT*** This information needs to be updated annually and each time the child's management plan is changed. Any medication required needs to be supplied at the time of submitting this form.**

CHILD'S NAME: ……..…… Age ..... Class ……Year …….

Address……..……

..……

Parents Contact Nos……..…..……(H)……

Mum (Work).....Mum (Mob).....

Dad (Work).....Dad (Mob).....

Local Emergency Contact Person:

Name…….. H Phone……..... Mobile……

Name…….. H Phone……..... Mobile……

Doctor: ..... Phone……

Medical condition/concerns: ……..…….

……..……

……..……

Common signs and symptoms:

……..

……..……

Trigger factors (if known):

……..

……..……

Emergency Treatment Action Plan:

1……

2……

3……..

4……..

NB: If your child has anaphylaxis, please disregard the above "boxed section" and ensure your doctor completes and SIGNS an "Action Plan for Anaphylaxis" and return it to the office together with this form.

Do you have Ambulance Cover? _____ I agree to pay for an ambulance if needed. _____

I, ……...hereby authorise St Jerome's Primary School staff to follow the emergency treatment procedure and to administer the ***supplied medication*** *when necessary. I acknowledge that I am responsible in keeping medication up to date and I also authorise St Jerome's to display my child's photograph.*

Signature ……. Date: …….....
(Parent or guardian)

Office					
Medication Provided	Yes □	No □	Is this child Anaphylactic	Yes □	No □
			Anaphylaxis Plan Provided	Yes □	No □