



Student Medical Information Booklet

Cherrybrook Technology High School

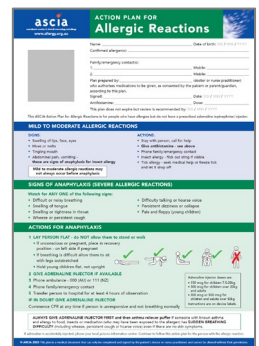
Please Complete this Booklet for Students with Health Conditions &/or Allergies

Students with any health conditions &/or allergies including, asthma, anaphylaxis, diabetes, epilepsy, learning disorders etc:

1. **Parent/Carer** to complete the **Authorisation to Contact Doctor** section (Appendix 2).

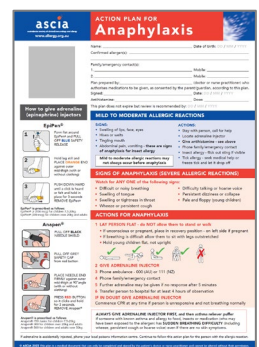
Students with a **Mild or Moderate Allergy**:

1. **Parent/Carer** to complete the **Students with Allergies** section (Appendix 1)
2. **Doctor** to complete the **green ASCIA Action Plan for Allergic Reactions** (included). **MUST BE COLOURED COPY!**



Students with **Anaphylaxis**:

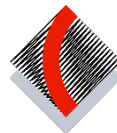
1. **Doctor** to complete the **Students with Allergies** sections (Appendix 1 & 3)
2. **Doctor** to complete the **red ASCIA Action Plan for Anaphylaxis** (included). **MUST BE COLOURED COPY!**



Students with **Asthma**:

1. **Doctor** to complete the **blue Asthma Action Plan** (included).





Appendix 1: Students with Allergies

This form is to be completed by the student's Parent / Carer, then returned promptly to the school's First Aid Officer.

The purpose of collecting this information is to identify students who are at risk of a severe allergic reaction. Information provided on this form will be used to assist the school in determining what action needs to be taken in relation to a student with an allergy and may be disclosed where required by law (for example if an ambulance is called to the school).

Student's full name: _____ DOB: _____

1. A Doctor has diagnosed my child with an allergy to:

Insect bite / sting (please specify): _____

Medication (please specify): _____

Latex

Other (please specify): _____

Food

• Peanuts Yes No

• Tree nuts Yes No

(if yes, please specify): _____

• Fish Yes No

• Shellfish Yes No

• Soy Yes No

• Sesame Yes No

• Wheat Yes No

• Milk Yes No

• Egg Yes No

• Other (please specify): _____

2. My child has been prescribed an adrenaline autoinjector (EpiPen® or Anapen®).

Yes No

3. My child has a **red** ASCIA Action Plan for Anaphylaxis (please attach and return with this form).

Yes No

4. My child has a **green** ASCIA Action Plan for Allergic Reactions (please attach and return with this form).

Yes No

5. My child has an ASCIA Action Plan for Drug (medication) Allergy (please attach and return with this form).

Yes No

I understand my child is responsible for carrying their adrenaline autoinjector, as well as their ASCIA Action Plan for Anaphylaxis, at all times.

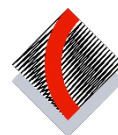
The school also requires you to provide an extra adrenaline autoinjector for your child in case of an emergency, which will be stored in a central location within the school.

Each time your child is prescribed a new adrenaline autoinjector, the Doctor will also issue you with an updated ASCIA Action Plan for Anaphylaxis. To ensure your child's safety, the updated adrenaline autoinjector and plan must be provided promptly to the school, as well as carried by your child.

Parent / Carer's full name: _____

Parent / Carer's signature: _____

Date: _____



Appendix 2: Authorisation to Contact Doctor

This form is to be completed by the Parent / Carer.

Student's full name: _____ DOB: _____

My child is currently enrolled or applying for enrolment at Cherrybrook Technology High School.

I understand:

1. The school may need to discuss the implications of my child's medical condition(s) with their treating Doctor, so the school can develop and implement an Individual Health Care Plan.
2. The information which may be sought by the school, includes information about my child's allergy and risk of anaphylaxis and any other condition which might impact on the school providing support for my child during school hours and during activities conducted under the care of the school.
3. Information provided by the Doctor to the school may be used or disclosed by school staff for the purposes of the development or implementation of the Individual Health Care Plan. I understand, the Department of Education / school can contact my child's Doctor to seek information to assist in the management of my child's medical condition at school.
4. I consent to the health care professional identified below, to provide the Department of Education / school with information about my child's allergy, risk of anaphylaxis and any other condition, including a learning disorder, which might impact on the school providing support for my child during school hours and during school-related activities.

Doctor's information:

Name: _____

Address: _____

Phone: _____

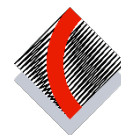
Mobile (if known): _____

Email (if known): _____

Parent / Carer's full name: _____

Parent / Carer's signature: _____

Date: _____



Appendix 3: 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 / patient's Individual Health Care Plan used by their school.

Please provide the appropriate ASCIA Action Plan for Anaphylaxis or ASCIA Action Plan for Allergic Reactions for this patient, **completed and signed**. 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 plans so the Parent / Carer can take them to their child's school for use as the school's emergency response plan.

Please include other information or details you believe are important in managing the severe allergy at school and during activities conducted under the care of the school. The additional information requested below will further assist the school in the development of the student's Individual Health Care Plan.

Student's full name: _____ DOB: _____

1. Does the student / patient have asthma?

Yes No

2. Does the student / patient have any other health conditions?

Yes No

If yes, please specify: _____

3. Does the student / patient have any other conditions which may impact on their ability to understand the nature of their anaphylaxis and the risk it poses to them. For example, developmental delay, language challenges, neurodiversity, behaviour challenges?

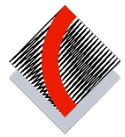
Yes No

If yes, please specify: _____

4. Have you discussed the condition(s) with the student / patient and their Parent / Carer?

Yes No

If you require further information, please phone the school on 9484 2144 and speak to the First Aid Officer.



Doctor's Information:

Name: _____

Address: _____

Phone: _____

Mobile (if known): _____

Email (if known): _____

Fax (if known): _____

Doctor's signature: _____

Date: _____

Parent / Carer's Declaration:

I consent to this information being provided for the school's use so they can develop an Individual Health Care Plan for my child.

I understand my child is responsible for carrying their adrenaline autoinjector, as well as their ASCIA Action Plan for Anaphylaxis and / or asthma medication and plan, at all times.

Parent / Carer's full name: _____

Parent / Carer's signature: _____

Date: _____

Name: _____ Date of birth: DD / MM / YYYY

Confirmed allergen(s): _____

Family/emergency contact(s):

1. _____ Mobile: _____

2. _____ Mobile: _____

Plan prepared by: _____ (prescriber)
who authorises medications to be given, as consented by the patient or parent/guardian,
according to this plan.

Signed: _____ Date: DD / MM / YYYY

Antihistamine: _____ Dose: _____

This plan does not expire but review is recommended by: DD / MM / YYYY

This ASCIA Action Plan for Allergic Reactions is for people who have allergies but do not have a prescribed adrenaline (epinephrine) device.

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting -
these are signs of anaphylaxis for insect allergy

Mild to moderate allergic reactions may not always occur before anaphylaxis

ACTIONS:

- Stay with person, call for help
- **Give antihistamine - see above**
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

Watch for ANY ONE of the following signs:

- Difficult or noisy breathing
- Swelling of tongue
- Swelling or tightness in throat
- Wheeze or persistent cough
- Difficulty talking or hoarse voice
- Persistent dizziness or collapse
- Pale and floppy (young children)
- Abdominal pain, vomiting
(these are signs of anaphylaxis for insect allergy)

ACTIONS FOR ANAPHYLAXIS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



2 GIVE ADRENALINE DEVICE IF AVAILABLE

- 3 Phone ambulance - 000 (AU) or 111 (NZ)
- 4 Phone family/emergency contact
- 5 Transfer person to hospital for at least 4 hours of observation

IF IN DOUBT GIVE ADRENALINE DEVICE

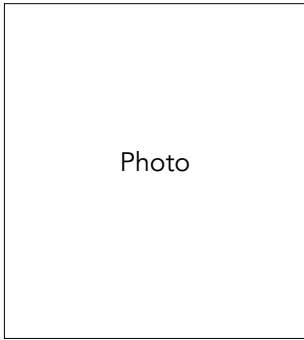
Commence CPR at any time if person is unresponsive or not breathing normally

Scan for adrenaline device instructions



ALWAYS GIVE ADRENALINE DEVICE FIRST, then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice). **Anaphylaxis can occur without skin symptoms.**

If adrenaline is accidentally injected or activated, use another device if available. If adrenaline is accidentally injected contact the local poisons information centre.



Name: _____ Date of birth: DD / MM / YYYY

Confirmed allergen(s): _____

Family/emergency contact(s):

1. _____ Mobile: _____

2. _____ Mobile: _____

Plan prepared by: _____ (prescriber) who authorises medications to be given, as consented by the parent/guardian, according to this plan.

Signed: _____ Date: DD / MM / YYYY

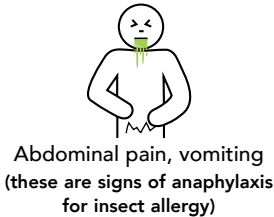
Adrenaline device/s prescribed: _____

Antihistamine: _____ Dose: _____

This plan does not expire but review is recommended by: DD / MM / YYYY

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS



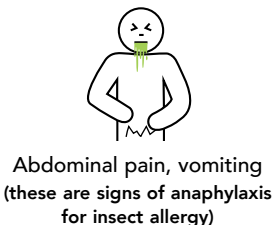
ACTIONS

- Stay with person, call for help
- Locate adrenaline (epinephrine) device
- Give antihistamine - see above
- Phone family/emergency contact
- Insect allergy - flick out sting if visible
- Tick allergy - seek medical help or freeze tick and let it drop off

Mild to moderate allergic reactions may not always occur before anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTIONS)

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS



ACTIONS

1 LAY PERSON FLAT - do NOT allow them to stand or walk

- If unconscious or pregnant, place in recovery position - on left side if pregnant
- If breathing is difficult allow them to sit with legs outstretched
- Hold young children flat, not upright



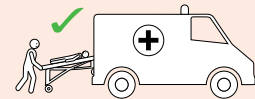
2 GIVE ADRENALINE DEVICE

3 Phone ambulance - 000 (AU) or 111 (NZ)

4 Phone family/emergency contact

5 Further adrenaline may be given if no response after 5 minutes

6 Transfer person to hospital for at least 4 hours of observation



5:00 minutes

IF IN DOUBT GIVE ADRENALINE DEVICE

Commence CPR at any time if person is unresponsive or not breathing normally

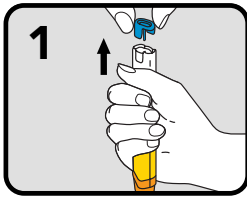


See page 2 for adrenaline device instructions or scan this code

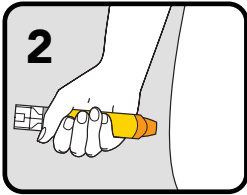
ALWAYS GIVE ADRENALINE DEVICE FIRST, then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication (who may have been exposed to the allergen) has **SUDDEN BREATHING DIFFICULTY** (including wheeze, persistent cough or hoarse voice). **Anaphylaxis can occur without skin symptoms.**

If device is accidentally injected or activated, use another adrenaline device if available. If adrenaline is accidentally injected, contact the local poisons information centre.

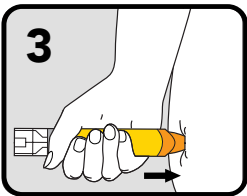
EpiPen®



1 Form fist around EpiPen® and pull off blue safety release



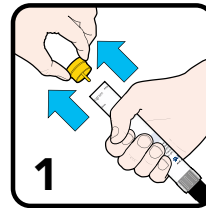
2 Hold leg still and place orange end against outer mid-thigh (with or without clothing)



3 Push down hard until a click is heard or felt and hold in place for 3 seconds. Remove EpiPen®

EpiPen® Jr (150 mcg) is prescribed for children 7.5 - 20kg
EpiPen® (300 mcg) is prescribed for children over 20kg and adults

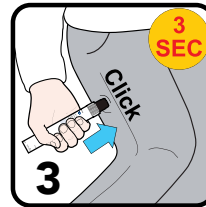
Jext®



1 Form fist around Jext® and pull off yellow cap



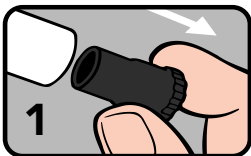
2 Place black injector tip against outer mid-thigh (with or without clothing)



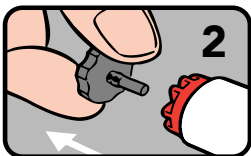
3 Push black tip firmly until a click is heard and hold in place for 3 seconds. Remove Jext®

Jext® Jr (150 mcg) is prescribed for children 7.5 - 20kg
Jext® (300 mcg) is prescribed for children over 20kg and adults

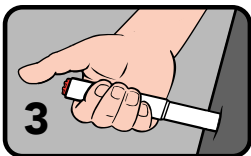
Anapen®



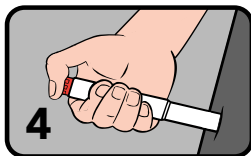
1 Pull off black needle shield



2 Pull off grey safety cap from red button



3 Place needle end firmly against outer mid-thigh at 90° angle (with or without clothing)



4 Press red button so it clicks and hold for 3 seconds. Remove Anapen®

Anapen® 500 is prescribed for children over 50kg and adults

neffy®



1 Hold as shown. Do not test spray



2 Place nozzle into nostril until fingers touch nose.



3 Press plunger firmly

neffy® 1mg is prescribed for children 15 - 30kg (4 years and over)
neffy® 2mg is prescribed for children and adults 30kg and over

Follow the ASCIA Action Plan or First Aid Plan for Anaphylaxis

Each device is for single-use only.

Give the used device to the ambulance with the time it was given.



Scan this QR code for instructions on the ASCIA website.

ASTHMA ACTION PLAN

Take this ASTHMA ACTION PLAN with you when you visit your doctor

ACTION PLAN FOR

Name
Date
Next asthma check-up due

DOCTOR'S CONTACT DETAILS

Name
Phone

EMERGENCY CONTACT DETAILS

Name
Phone
Relationship



WHEN WELL

Asthma under control (almost no symptoms)

ALWAYS CARRY YOUR RELIEVER WITH YOU

Your preventer is:
(NAME & STRENGTH)

Take puffs/tablets times every day
 Use a spacer with your inhaler

Your reliever is:
(NAME)

Take puffs

When: You have symptoms like wheezing, coughing or shortness of breath
 Use a spacer with your inhaler

Peak flow* (if used) above:

OTHER INSTRUCTIONS

(e.g. other medicines, trigger avoidance, what to do before exercise)



WHEN NOT WELL

Asthma getting worse (needing more reliever than usual, having more symptoms than usual, waking up with asthma, asthma is interfering with usual activities)

Keep taking preventer:
(NAME & STRENGTH)

Take puffs/tablets times every day

Use a spacer with your inhaler

Your reliever is:
(NAME)

Take puffs

Use a spacer with your inhaler

Peak flow* (if used) between and

OTHER INSTRUCTIONS

(e.g. other medicines, when to stop taking extra medicines)

Contact your doctor



IF SYMPTOMS WORSEN

Severe asthma flare-up/attack (needing reliever again within 3 hours, increasing difficulty breathing, waking often at night with asthma symptoms)

Keep taking preventer:
(NAME & STRENGTH)

Take puffs/tablets times every day

Use a spacer with your inhaler

Your reliever is:
(NAME)

Take puffs

Use a spacer with your inhaler

Peak flow* (if used) between and

OTHER INSTRUCTIONS

(e.g. other medicines, when to stop taking extra medicines)

Contact your doctor today

Prednisolone/prednisone:

Take each morning for days



DANGER SIGNS

Asthma emergency (severe breathing problems, symptoms get worse very quickly, reliever has little or no effect)

**DIAL 000 FOR
AMBULANCE**

Peak flow (if used) below:

Call an ambulance immediately
Say that this is an asthma emergency
Keep taking reliever as often as needed

Use your adrenaline autoinjector (EpiPen or Anapen)



**National
Asthma
Council
AUSTRALIA**

nationalasthma.org.au

ASTHMA ACTION PLAN

WHAT TO LOOK OUT FOR

WHEN WELL



THIS MEANS:

- you have no night-time wheezing, coughing or chest tightness
- you only occasionally have wheezing, coughing or chest tightness during the day
- you need reliever medication only occasionally or before exercise
- you can do your usual activities without getting asthma symptoms

WHEN NOT WELL



THIS MEANS ANY ONE OF THESE:

- you have night-time wheezing, coughing or chest tightness
- you have morning asthma symptoms when you wake up
- you need to take your reliever more than usual
- your asthma is interfering with your usual activities

THIS IS AN ASTHMA FLARE-UP

IF SYMPTOMS GET WORSE



THIS MEANS:

- you have increasing wheezing, cough, chest tightness or shortness of breath
- you are waking often at night with asthma symptoms
- you need to use your reliever again within 3 hours

THIS IS A SEVERE ASTHMA ATTACK (SEVERE FLARE-UP)

DANGER SIGNS



THIS MEANS:

- your symptoms get worse very quickly
- you have severe shortness of breath, can't speak comfortably or lips look blue
- you get little or no relief from your reliever inhaler

CALL AN AMBULANCE IMMEDIATELY: DIAL 000
SAY THIS IS AN ASTHMA EMERGENCY

**DIAL 000 FOR
AMBULANCE**

ASTHMA MEDICINES

PREVENTERS

Your preventer medicine reduces inflammation, swelling and mucus in the airways of your lungs. Preventers need to be taken **every day**, even when you are well.

Some preventer inhalers contain 2 medicines to help control your asthma (combination inhalers).

RELIEVERS

Your reliever medicine works quickly to make breathing easier by making the airways wider.

Always carry your reliever with you – it is essential for first aid. Do not use your preventer inhaler for quick relief of asthma symptoms unless your doctor has told you to do this.

To order more Asthma Action Plans visit the National Asthma Council website.
A range of action plans are available on the website – please use the one that best suits your patient.

nationalasthma.org.au

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**National
Asthma
Council**
AUSTRALIA