



MEDICAL MANAGEMENT PLAN: ALLERGIES

CHILD'S
PHOTO

Name: _____

Age: _____ DOB: _____

SIGNS & SYMPTOMS:

INITIAL

SEVERE

WHAT TO DO IF A REACTION OCCURS:

REFER TO APPROPRIATE ACTION PLAN – HIGHLIGHTED IN THE OFFICE.
IF SEVERE, CALL AN AMBULANCE IMMEDIATELY

000

CONTACT NAMES:

	Mother	Father	Doctor	Other
Name				
Phone (H)				
Phone (W)				
Mobile				
Address				

AUTHORISATION FOR MANAGEMENT PLAN TO BE FOLLOWED:

I/We _____, being the mother/father/guardian of _____ hereby
authorise any Staff Member of Camp Australia OSHC Service, to administer allergy medication to my child, if necessary.
Medication provided by me, the parent will be kept at the OSHC Service at all times.

BEGINNING OF EACH TERM

A meeting between the parent/s and staff must be scheduled to ensure that this Management Plan and medication provided are still applicable to the child's condition
Medication must be correctly labelled with name of medication, child's name, dosage, circumstances for administration of it to child.
Each party is required to sign the Plan in the table below to confirm the above information is still current.

Date	Term 1:	Term 2:	Term 3:	Term 4:
Parent				
Staff				
Medication still valid: Y/N				