IRYMPLE
SECONDARY COLLEGE
Karadoc Avenue, Irymple VIC 3498
Telephone: 03 5024 5407
Email: irymple.sc@education.vic.gov.au
Web: www.irysec.vic.gov.au

Dear Parent/Guardian

To ensure that all staff are aware of and able to respond to your child's medical needs while they are at school, you will then need to complete and return the appropriate form or action plan listed below.

For incoming Year 7s we will require these to be returned prior to Orientation Day. For all other students we will require them to be returned on or before the first day of Term 1. All medication is to be supplied and appropriately labelled.

We offer a Doctors in Schools Program operating each Tuesday morning for current students. This may be an option for you to complete these required documents and action plans. Appointments can be made through the front office. Students will not be able to attend any excursions, events or sporting programs without the required documents and medication.

Our First Aid Officers, Sue McPhee and Megan Hammond can assist you with enquiries at any stage.

Student Name: _____

CONDITION	FORM REQUIRED ALONG WITH ALL PRESCRIBED MEDICATION, CLEARLY LABELLED
General Health Condition	o General Medical Advice Form o Student Health Support Plan, if deemed appropriate o Medication Authority Form, if medication is to be administered at school
Asthma	o Asthma Care Plan o Student Health Support Plan
Anaphylaxis	o Action Plan for Anaphylaxis (Red)
Allergy	o Action Plan for Allergic Reactions (Green) o Individual Allergic Reactions Management Plan o Medication Authority Form, if medication is to be administered at school
Epilepsy	o Epilepsy Management Plan o Student Health Support Plan o Medication Authority Form, if medication is to be administered at school
Diabetes	o Diabetes School Action Plan o Student Health Support Plan o Medication Authority Form, if medication is to be administered at school
Acquired Brain Injury	o Student Health Support Plan o Medication Authority Form, if medication is to be administered at school o *please contact the office for Management Plan
Cystic Fibrosis	o Student Health Support Plan o Medication Authority Form, if medication is to be administered at school o *please contact the office for Management Plan
Cancer	o Student Health Support Plan o Medication Authority Form, if medication is to be administered at school o *please contact the office for Management Plan

IRYMPLE
SECONDARY COLLEGE

GENERAL MEDICAL ADVICE FORM

for a student with a health condition

This form is to be completed by the student's medical/health practitioner providing a description of the health condition and first aid requirements for a student with a health condition. This form will assist the school in developing a Student Health Support Plan which outlines how the school will support the student's health care needs.

Please only complete those sections in this form which are relevant to the student's health support needs.

Name of School: Irymple Secondary College

Student's Name: _____ Date of Birth: _____

MedicAlert Number (if relevant): _____ Review date for this form: _____

DESCRIPTION OF THE CONDITION

Observable signs and symptoms:

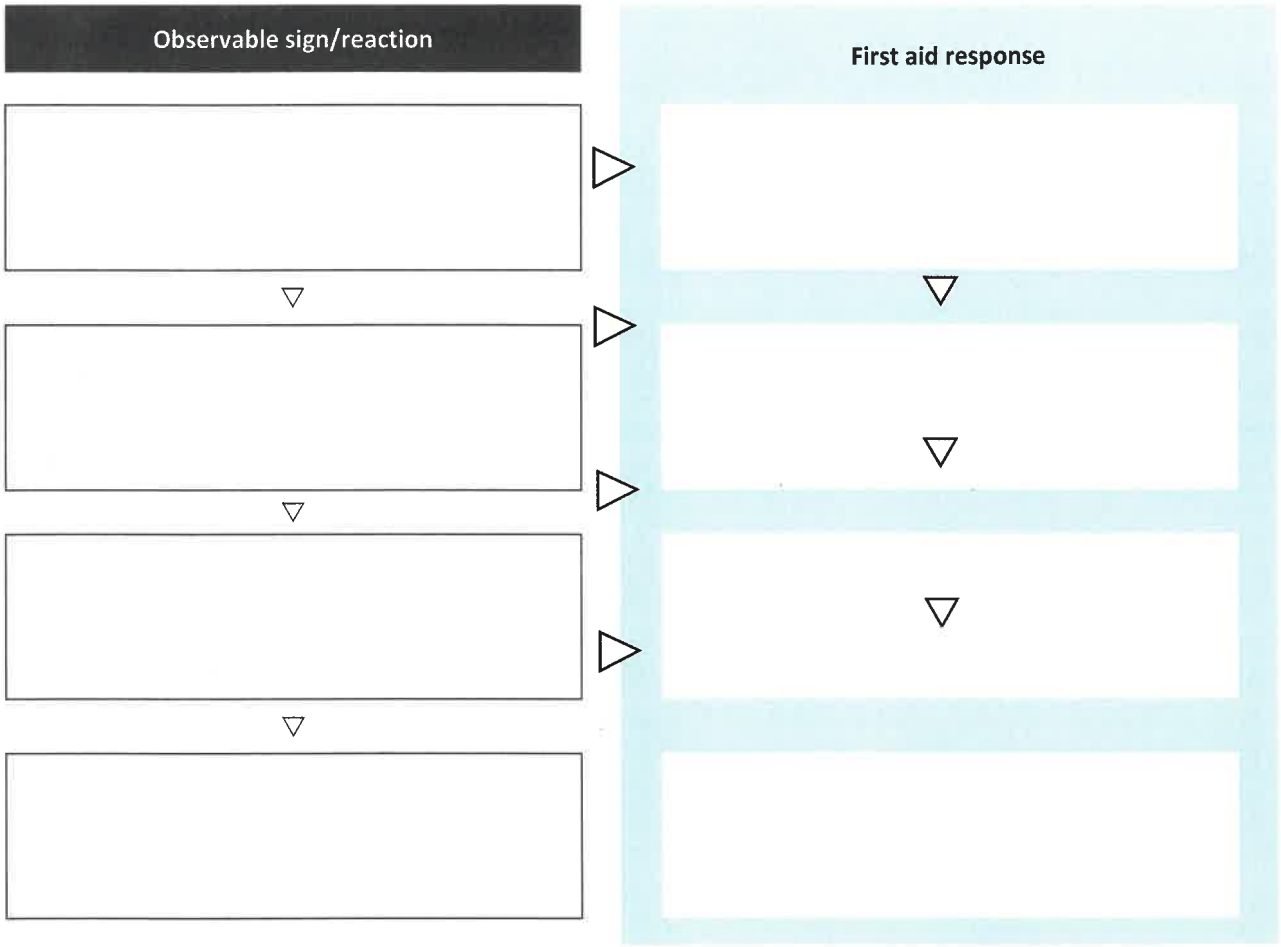
Frequency and severity:

Triggers (if applicable):

Possible impact on school-based activities (student's learning, physical activities):

FIRST AID

If the student becomes ill or injured at school, the school will administer first aid and call an ambulance if necessary. If you anticipate the student will require anything other than a standard first aid response, please provide details on the next page, so special arrangement can be negotiated.



Privacy Statement
The school collects personal information so as the school can plan and support the health care needs of the student. Without the provision of this information the quality of the health support provided may be affected. The information may be disclosed to relevant school staff and appropriate medical personnel, including those engaged in providing health support as well as emergency personnel, where appropriate, or where authorised or required by another law. You are able to request access to the personal information that we hold about you/your child and to request that it be corrected. Please contact the school directly or FOI Unit on 96372670.

Authorisation:
Name of Medical/health practitioner:
Professional Role:
Signature: Date:
Contact details:
Name of Parent/Carer or adult/independent student **:
Signature: Date:

If additional advice is required, please attach it to this form

**Please note: Adult student is a student who is eighteen years of age and older. Independent student is a student under the age of eighteen years and living separately and independently from parents/guardians (See: Decision Making Responsibility for Students - School Policy and Advisory Guide).

STUDENT HEALTH SUPPORT PLAN

This plan outlines how the school will support the student's health care needs, based on health advice received from the student's medical/health practitioner. This form must be completed for each student with an identified health care need (not including those with Anaphylaxis as this is done via an Individual Anaphylaxis Management Plan.) See http://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx.

This Plan is to be completed by the principal or nominee in collaboration with the parent/carer and student.

School: Irymple Secondary College		Phone: 03 5024 5407
Student's name:		Date of birth:
Year level:		Proposed date for review:
Parent/carer contact information (1)	Parent/carer contact information (2)	Other emergency contacts (if parent/carer not available)
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Home phone:	Home phone:	Home phone:
Work phone:	Work phone:	Work phone:
Mobile:	Mobile:	Mobile:
Address:	Address:	Address:
Medical /Health practitioner contact:		

Ideally, this plan should be developed based on health advice received via the appropriate Departmental Medical Advice form or in case of asthma, the Asthma Foundation's *School Asthma Action Plan*. Please tick the appropriate form which has been completed and attach to this Plan. All forms are available from the Health Support Planning Forms – School Policy and Advisory Guide

- ☐ ***General Medical Advice Form - for a student with a health condition***
- ☐ ***School Asthma Action Plan***
- ☐ ***Condition Specific Medical Advice Form – Cystic Fibrosis***
- ☐ ***Condition Specific Medical Advice Form – Acquired Brain Injury***
- ☐ ***Condition Specific Medical Advice Form – Cancer***
- ☐ ***Condition Specific Medical Advice Form – Diabetes***
- ☐ ***Condition Specific Medical Advice Form – Epilepsy***
- ☐ ***Personal Care Medical Advice Form - for a student who requires support for transfers and positioning***
- ☐ ***Personal Care Medical Advice Form - for a student who requires support for oral eating and drinking***
- ☐ ***Personal Care Medical Advice Form - for a student who requires support for continence***

List who will receive copies of this *Student Health Support Plan*:

1. Student's Family 2. Other: 3.

The following *Student Health Support Plan* has been developed with my knowledge and input

Name of parent/carer: _____ Signature: _____ Date: _____

Name of principal (or nominee): : _____ Signature: _____ Date: _____

Privacy Statement
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HOW THE SCHOOL WILL SUPPORT THE STUDENT'S HEALTH CARE NEEDS

Student's name:	
Date of birth:	Year level:
What is the health care need identified by the student's medical/health practitioner?	
Other known health conditions:	
When will the student commence attending school?	
Detail any actions and timelines to enable attendance and any interim provisions:	

Below are some questions that may need to be considered when detailing the support that will be provided for the student's health care needs. These questions should be used as a guide only.

Support	What needs to be considered?	Strategy – how will the school support the student's health care needs?	Person Responsible for ensuring the support
Overall Support	Is it necessary to provide the support during the school day?	*For example, some medication can be taken at home and does not need to be brought to the school.*	
	How can the recommended support be provided in the simplest manner, with minimal interruption to the education and care program?	*For example, students using nebulisers can often learn to use puffers and spacers at school.*	
	Who should provide the support?	*For example, the principal, should conduct a risk assessment for staff and ask:* - *Does the support fit with assigned staff duties and basic first aid training (see the Department First Aid Policy www.education.vic.gov.au/hrweb/ohs/health/firstaid.htm)* - *If so, can it be accommodated within current resources?* - *If not, are there additional training modules available*	
	How can the support be provided in a way that respects dignity, privacy, comfort and safety and enhances learning?	*For example, detail the steps taken to ensure that the support provided respects the students, dignity, privacy, comfort and safety and enhances learning.*	

Support	What needs to be considered?	Strategy – how will the school support the student's health care needs?	Person Responsible for ensuring the support
First Aid	Does the school require relevant staff to undertake additional training modules not covered under basic first aid training, such as staff involved with excursions and specific educational programs or activities	*Ensure that relevant staff undertake the agreed additional training* *Ensure that there are interim provisions in place (whilst awaiting the staff member to receive training), to ensure the student's attendance at school.*	
	Does the medical/health information highlight any individual first aid requirements for the student, other than basic first aid?	*Discuss and agree on the individual first aid plan with the parent/carer.* *Ensure that there are sufficient staff trained in basic first aid (see the Department's First Aid Policy www.education.vic.gov.au/hrweb/ohs/health/firstaid.htm)* *Ensure that all relevant school staff are informed about the first aid response for the student*	
Complex/ Invasive health care needs	Does the student have a complex medical care need?	*Is specific training required by relevant school staff to meet the student's complex medical care need?* *Can the training be obtained through the Department funded Schoolcare Program? If so, the School should complete the relevant referral forms which can be accessed by contacting the Royal Children's Hospital's Home and Community Care on 9345 6548.* *Consider if the following program/services are required: the Program for Students with Disabilities or Visiting Teachers Service.*	
Routine Supervision for health-related safety	Does the student require medication to be administered and/or stored at the School?	*Ensure that the parent/carer is aware of the School's policy on medication management.* *Ensure that written advice is received, ideally from the student's medical/health practitioner for appropriate storage and administration of the medication – via the Department's Medication Authority Form* *Ensure that a medication log or equivalent official medications register is completed by the person administering the taking of the medication.*	
	Are there any facilities issues that need to be addressed?	*Ensure the schools first aid room/sick bay and its contents provide the minimum requirements and discuss and agree if other requirements are needed in this room to meet the student's health care needs.* *Ensure the school provides sufficient facilities to assist a student who requires a wheelchair or other technical support. Discuss this with the parent/carer/student*	
	Does the student require assistance by a visiting nurse, physiotherapist, or other health worker?	*Detail who the worker is, the contact staff member and how, when and where they will provide support.* *Ensure that the school provides a facility which enables the provision of the health service*	
	Who is responsible for management of health records at the school?	*Ensure that information privacy principles are applied when collecting, using, retaining or disposing of personal or health information.*	
	Where relevant, what steps have been put in place to support continuity and relevance of curriculum for the student?	*For example, accommodation in curriculum design and delivery and in assessment for a student in transition between home, hospital and school; for a student attending part-time or episodically.*	

Support	What needs to be considered?	Strategy – how will the school support the student's health care needs?	Person Responsible for ensuring the support
Personal Care	Does the medical/health information highlight a predictable need for additional support with daily living tasks?	*Detail how the school will support the student's personal care needs, for example in relation to nose blowing, washing hands, continence care* *Would the use of a care and learning plan for toileting or hygiene be appropriate?*	
Other considerations	Are there other considerations relevant for this health support plan?	*For example, in relation to behaviour, such as special permission to leave group activities as needed; planned, supportive peer environment.* *For example, in relation to the environment, such as minimising risks such as allergens or other risk factors.* *For example, in relation to communication, is there a need to formally outline the communication channels between the school, family and health/medical practitioner?* *For example, is there a need for planned support for siblings/peers?*	

IRYMPLE
SECONDARY COLLEGE

MEDICATION AUTHORITY FORM

for a student who requires medication whilst at school

This form should be completed ideally by the student's medical/health practitioner, for all medication to be administered at school. For those students with asthma, an Asthma Foundation's *School Asthma Action Plan* should be completed instead. For those students with anaphylaxis, an ASCIA *Action Plan for Anaphylaxis* should be completed instead. These forms are available from the Australasian Society of Clinical Immunology and Allergy (ASCIA): http://www.allergy.org.au/health-professionals/ascia-plans-action-and-treatment.

Please only complete those sections in this form which are relevant to the student's health support needs.

Name of School: Irymple Secondary College

Student's Name: _____ Date of Birth: _____

MedicAlert Number (if relevant): _____ Review date for this form: _____

Please Note: wherever possible, medication should be scheduled outside the school hours, e.g. medication required three times a day is generally not required during a school day: it can be taken before and after school and before bed.

Medication required:				
Name of Medication/s	Dosage (amount)	Time/s to be taken	How is it to be taken? (eg orally/ topical/injection)	Dates
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication
				Start date: / / End Date: / / □ Ongoing medication

Medication Storage

Please indicate if there are specific storage instructions for the medication:

.....

.....

Continued over page...

Medication delivered to the school

Please ensure that medication delivered to the school:

☐ - Is in its original package

☐ - The pharmacy label matches the information included in this form.

Self-management of medication

Students in the early years will generally need supervision of their medication and other aspects of health care management. In line with their age and stage of development and capabilities, older students can take responsibility for their own health care. Self-management should follow agreement by the student and his or her parents/carers, the school and the student's medical/health practitioner.

Please advise if this person's condition creates any difficulties with self-management, for example, difficulty remembering to take medication at a specified time or difficulties coordinating equipment:

.....

.....

.....

Monitoring effects of Medication

Please note: School staff *do not* monitor the effects of medication and will seek emergency medical assistance if concerned about a student's behaviour following medication.

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Authorisation:
Name of Medical/health practitioner:
Professional Role:
Signature: Date:
Contact details:
Name of Parent/Carer or adult/Mature minor:**
Signature: Date:

If additional advice is required, please attach it to this form

**Please note: Mature minor is a student who is capable of making their own decisions on a range of issues, before they reach eighteen years of age. (See: Decision Making Responsibility for Students - School Policy and Advisory Guide).

IRYMPLE
SECONDARY COLLEGE

INDIVIDUAL ALLERGIC REACTIONS MANAGEMENT PLAN

This plan is to be completed by the principal or nominee in consultation with the parents/s on the basis of information from the student's medical practitioner (green **ASCIA Action Plan for Allergic Reactions**) provided by the parent. It is the parents' responsibility to provide the school with a copy of the student's ASCIA Action Plan for Allergic Reactions (completed by the student's medical practitioner) and an up-to-date photo of the student - to be appended to this plan; and to inform the school if their child's medical condition changes.

School	Irymple Secondary College	**Phone**	03 5024 5407
Student			
DOB		**Year level**	
Mild to moderate allergy to:			
Other health conditions			
Medication at school			
EMERGENCY CONTACT DETAILS (PARENT)			
Name		**Name**	
Relationship		**Relationship**	
Home phone		**Home phone**	
Work phone		**Work phone**	
Mobile		**Mobile**	
Address		**Address**	
EMERGENCY CONTACT DETAILS (ALTERNATE)			
Name		**Name**	
Relationship		**Relationship**	
Home phone		**Home phone**	
Work phone		**Work phone**	
Mobile		**Mobile**	
Address		**Address**	
Medical practitioner contact	**Name**		
	Phone		

ENVIRONMENT			
To be completed by principal or nominee. Please consider each environment/area (on and off school site) the student will be in for the year, e.g. classroom, canteen, food tech room, sports oval, excursions and camps etc.			
Name of environment/area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/area:			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**

This Individual Allergic Reactions Management Plan will be reviewed on any of the following occurrences (whichever happens earlier):

- annually
- if the student's medical condition, insofar as it relates to allergy, changes
- as soon as practicable after the student has an allergic reaction in the care of the school

In addition to the above, this plan should be reviewed by the school staff in charge, immediately prior to any off-site activity, such as camps and excursions, or at special events conducted, organised or attended by the school (eg. class parties, elective subjects, cultural days, fetes, incursions) which the student to whom this plan applies is attending.

I have been consulted in the development of this Individual Allergic Reactions Management Plan.

I consent to the risk minimisation strategies proposed.

Risk minimisation strategies are available at Chapter 8 – Risk Minimisation Strategies of the Anaphylaxis Guidelines

Signature of parent:	
Date:	
I have consulted the parents of the student and the relevant school staff who will be involved in the implementation of this Individual Allergic Reactions Management Plan.	
Signature of principal (or nominee):	
Date:	

ASTHMA CARE PLAN FOR EDUCATION AND CARE SERVICES

PHOTO OF STUDENT (OPTIONAL)

CONFIDENTIAL: Staff are trained in asthma first aid (see overleaf) and can provide routine asthma medication as authorised in this care plan by the treating doctor. Please advise staff in writing of any changes to this plan.

To be completed by the treating doctor and parent/guardian, for supervising staff and emergency medical personnel.

Plan date
___/___/20___

Review date
___/___/20___

PLEASE PRINT CLEARLY

Student's name: _____ DOB: _____

MANAGING AN ASTHMA ATTACK

Staff are trained in asthma first aid (see overleaf). Please write down anything different this student might need if they have an asthma attack:

_____

_____

_____

DAILY ASTHMA MANAGEMENT

This student's usual asthma signs:

- ☐ Cough
- ☐ Wheeze
- ☐ Difficulty breathing
- ☐ Other (please describe):

_____

_____

Frequency and severity:

- ☐ Daily/most days
- ☐ Frequently (more than 5 x per year)
- ☐ Occasionally (less than 5 x per year)
- ☐ Other (please describe)

_____

_____

Known triggers for this student's asthma (e.g. exercise*, colds/flu, smoke) — please detail:

_____

_____

_____

_____

_____

Does this student usually tell an adult if s/he is having trouble breathing?	☐ **Yes**	☐ **No**
Does this student need help to take asthma medication?	☐ **Yes**	☐ **No**
Does this student use a mask with a spacer?	☐ **Yes**	☐ **No**
*Does this student need a blue/grey reliever puffer medication before exercise?	☐ **Yes**	☐ **No**

MEDICATION PLAN

If this student needs asthma medication, please detail below and make sure the medication and spacer/mask are supplied to staff.

NAME OF MEDICATION AND COLOUR	DOSE/NUMBER OF PUFFS	TIME REQUIRED

DOCTOR

Name of doctor _____

Address _____

Phone _____

Signature _____ Date _____

PARENT/GUARDIAN

I have read, understood and agreed with this care plan and any attachments listed. I approve the release of this information to staff and emergency medical personnel. I will notify the staff in writing if there are any changes to these instructions. I understand staff will seek emergency medical help as needed and that I am responsible for payment of any emergency medical costs.

Signature _____ Date _____

Name _____

EMERGENCY CONTACT INFORMATION

Contact name _____

Phone _____

Mobile _____

Email _____

For asthma information and support or to speak with an Asthma Educator call **1800 ASTHMA** (1800 278 462) or visit **asthma.org.au**

ASTHMA AUSTRALIA

ASTHMA FIRST AID

1 SIT THE PERSON UPRIGHT

- Be **calm** and reassuring
- **Do not leave** them alone

2 GIVE 4 SEPARATE PUFFS OF BLUE/GREY RELIEVER PUFFER

- **Shake** puffer
- Put **1 puff** into spacer
- Take **4 breaths** from spacer

– **Repeat** until **4 puffs** have been taken

– **Remember: Shake, 1 puff, 4 breaths**

OR give 2 separate doses of a Bricanyl inhaler (age 6 & over) or a Symbicort inhaler (over 12)

3 WAIT 4 MINUTES

- If there is no improvement, **give 4 more separate puffs of blue/grey reliever** as above

OR give 1 more dose of Bricanyl or Symbicort inhaler

IF THERE IS STILL NO IMPROVEMENT

4 DIAL TRIPLE ZERO (000)

- Say **'ambulance'** and that someone is having an asthma attack
- Keep giving **4 separate puffs** every **4 minutes** until emergency assistance arrives

OR give 1 dose of a Bricanyl or Symbicort every 4 minutes – up to 3 more doses of Symbicort

Translating and Interpreting Service
131 450

ASTHMA AUSTRALIA

Contact Asthma Australia

1800 ASTHMA
(1800 278 462)

asthma.org.au

CALL EMERGENCY ASSISTANCE IMMEDIATELY AND DIAL TRIPLE ZERO (000) IF:

- the person is not breathing
- the person's asthma suddenly becomes worse or is not improving
- the person is having an asthma attack and a reliever is not available
- you are not sure if it's asthma
- the person is known to have Anaphylaxis – follow their Anaphylaxis Action Plan, then give Asthma First Aid

Blue/grey reliever medication is unlikely to harm, even if the person does not have asthma.

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australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises:

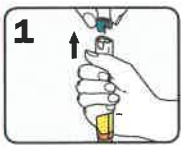
- ☐ Medications specified on this plan to be administered according to the plan.
- ☐ Prescription of 2 adrenaline autoinjectors.
- ☐ Review of this plan is due by the date below.

Date: _____

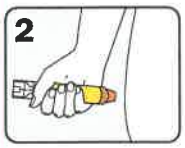
Signed: _____

Date: _____

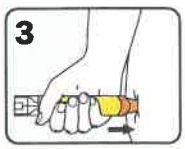
How to give EpiPen® adrenaline (epinephrine) autoinjectors



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



Hold leg still and PLACE ORANGE END against outer mid-thigh (with or without clothing)



PUSH DOWN HARD until a click is heard or felt and hold in place for 3 seconds

REMOVE EpiPen®

EpiPen® is prescribed for children over 20kg and adults. EpiPen®Jr is prescribed for children 7.5-20kg.

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Locate adrenaline autoinjector
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **Difficult/noisy breathing**
- **Swelling of tongue**
- **Swelling/tightness in throat**
- **Wheeze or persistent cough**
- **Difficulty talking and/or hoarse voice**
- **Persistent dizziness or collapse**
- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk

- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**

2 Give adrenaline autoinjector

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

4 Phone family/emergency contact

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

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

If in doubt give adrenaline autoinjector

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

ALWAYS give adrenaline autoinjector FIRST, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

- ***If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre.***
- ***Continue to follow this action plan for the person with the allergic reaction.***

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by medical or nurse practitioner:

_____

I hereby authorise medications specified on this plan to be administered according to the plan

Signed:

_____

Date: _____

Action Plan due for review – date:

_____

Note: This ASCIA Action Plan for Allergic Reactions is for people with mild to moderate allergies, who need to avoid certain allergens.

For people with severe allergies (and at risk of anaphylaxis) there are red ASCIA Action Plans for Anaphylaxis (brand specific or generic versions) for use with adrenaline (epinephrine) autoinjectors.

Instructions are on the device label.

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 10-20kg.

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- Give other medications (if prescribed).....
- Phone family/emergency contact

Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

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- **Pale and floppy (young children)**

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk

- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**

2 Give adrenaline (epinephrine) autoinjector 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 autoinjector

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

ALWAYS give adrenaline autoinjector FIRST if available, and then asthma reliever puffer if someone with known asthma and allergy to food, insects or medication has SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice) even if there are no skin symptoms

Asthma reliever medication prescribed: ☐ Y ☐ N

- *If adrenaline is accidentally injected (e.g. into a thumb) phone your local poisons information centre.*
- *Continue to follow this action plan for the person with the allergic reaction.*

EPILEPSY: KNOW ME, SUPPORT ME.

Insert jpeg image here

Epilepsy Management Plan

Name of person living with epilepsy:

Date of birth: | Date plan written: | Date to review:

1. General information

Medication records located:

Seizure records located:

General support needs document located:

Epilepsy diagnosis (if known):

2. Has emergency epilepsy medication been prescribed? Yes ☒ No ☐

If yes, the medication authority or emergency medication plan must be attached and followed*, if you are specifically trained.

These documents are located:

3. My seizures are triggered by: (if not known, write no known triggers)

4. Changes in my behaviour that may indicate a seizure could occur:

(For example pacing, sad, irritability, poor appetite, usually very mobile but now sitting quietly)

5. My seizure description and seizure support needs:

(Complete a separate row for each type of seizure – use brief, concise language to describe each seizure type.)

Description of seizure (Make sure you describe what the person looks like before, during and after and if they typically occur in a cluster)	**Typical duration of seizure** (seconds/ minutes)	**Usual frequency of seizure** (state in terms of seizures per month, per year or per day)	**Is emergency medication prescribed for this type of seizure?**	**When to call an ambulance** If you are trained in emergency medication administration* refer to the emergency medication plan and the medication authority
			Yes ☐ No ☐	If you are untrained in emergency medication, call ambulance when:

6. How I want to be supported during a seizure:

Specify the support needed during each of the different seizure types.

(If you are ever in doubt about my health during or after the seizure, call an ambulance)

7. My specific post-seizure support:

State how a support person would know when I have regained my usual awareness and how long it typically takes for me to fully recover. How I want to be supported. Describe what my post seizure behaviour may look like.

8. My risk/safety alerts:

For example bathing, swimming, use of helmet, mobility following seizure.

Risk	What will reduce this risk for me?

9. Do I need additional overnight support? Yes ☐ No ☐

If 'yes' describe:

This plan has been co-ordinated by:

Name:	Organisation (if any):
Telephone numbers:	
Association with person: (For example treating doctor, parent, key worker in group home, case manager)	
Client/parent/guardian signature (if under age):	

Endorsement by treating doctor:

Your doctor's name:

Telephone:

Doctor's signature:	[illegible]	Date:

Australia wide epilepsy help line 1300 852 853

epilepsy foundation

TYPE 1 DIABETES ACTION PLAN 2022 SCHOOL SETTING

Use in conjunction with Diabetes Management Plan. This plan should be reviewed every year.

Insulin pump

STUDENT'S NAME

DATE OF BIRTH GRADE / YEAR

NAME OF SCHOOL

INSULIN The insulin pump continually delivers insulin. The pump will deliver insulin based on carbohydrate food amount and BGL entries.

- ☐ Hybrid closed loop (read and respond to pump commands)

Pump button pushing:

☐ independent ☐ with supervision ☐ with assistance

THIS STUDENT IS WEARING

- ☐ Continuous Glucose Monitoring (CGM)
- ☐ Flash Glucose Monitoring (FGM)

BLOOD GLUCOSE LEVEL (BGL) CHECKING TIMES

BGL check should occur where the student is at the time it is required

- ☐ Before main meal
- ☐ Anytime hypo is suspected
- ☐ Confirm low or high sensor glucose reading
- ☐ Before physical education / sport
- ☐ Before exams or tests

PHYSICAL EDUCATION (PE) / SPORT

- Some students **MAY** require a BGL check before PE/sport.
- Vigorous activity **should not** be undertaken if BGL is greater than or equal to 15.0 **and** blood ketones are greater than or equal to 0.6.

PARENT / CARER NAME _____

CONTACT NO. _____

DIABETES TREATING TEAM _____

CONTACT NO. _____

DATE PLAN CREATED _____

LOW Hypoglycaemia (Hypo)

Blood Glucose Level (BGL) less than 4.0 mmol/L

SIGNS AND SYMPTOMS Pale, headache, shaky, sweaty, dizzy, drowsy, changes in behaviour

Note: Check BGL if hypo suspected

Symptoms may not always be obvious

DO NOT LEAVE STUDENT ALONE
DO NOT DELAY TREATMENT

MILD

Student conscious
(Able to eat hypo food)

Step1: Give fast acting carbohydrate
e.g. _____

Step 2: Recheck BGL in 15 mins

- If BGL less than 4.0, repeat **Step 1**
- If BGL greater than or equal to 4.0, go to **Step 3**

Step 3:
If starting BGL between **2.0–4.0** **No** follow up slow acting carbohydrate required

Step 3:
If starting BGL **less than 2.0** **Give slow acting carbohydrate**
e.g. _____
_____

Step 4: Resume normal activity when BGL 4.0 or higher

SEVERE

Student drowsy / unconscious
(Risk of choking / unable to swallow)

First Aid DRSABCD
Stay with student

CALL AN AMBULANCE
DIAL 000

Contact parent/carer when safe to do so

HIGH Hyperglycaemia (Hyper)

Blood Glucose Level (BGL) greater than or equal to 15.0 mmol/L is well above target and requires additional action

SIGNS AND SYMPTOMS Increased thirst, extra toilet visits, poor concentration, irritability, tiredness

Note: Symptoms may not always be obvious

Check blood ketones
Blood ketones greater than or equal to 0.6 mmol/L requires immediate treatment

Blood ketones less than 0.6

- Enter BGL into pump
- Accept Correction bolus
- 1–2 glasses water per hour; extra toilet visits may be required
- Recheck BGL in 2 hours

BGL less than 15.0 and ketones less than 0.6
No further action

BGL still greater than or equal to 15.0 and ketones less than 0.6
Potential line failure

Blood ketones greater than or equal to 0.6

POTENTIAL LINE FAILURE

- Will need injected insulin and line change
- This is the parent/carer responsibility or student (if they have the required insulin pump skills)

If unable to contact parent/carer
CALL AN AMBULANCE
DIAL 000

IF UNWELL (E.G. VOMITING), CONTACT PARENT/ CARER TO COLLECT STUDENT

diabetes victoria · The Royal Children's Hospital Melbourne · Monash Children's Hospital