



Ivanhoe Primary School **Notification of an Allergic Reaction**

In order to provide appropriate care/treatment for students who suffer from severe allergic reactions, it is important that we have the following information.

If your child/children suffer from severe allergic reactions, please complete all sections of the form below and return to the school as soon as possible. Please complete a separate form for each child.

It is imperative that we have a management plan completed and signed by your doctor.

If your child suffers from Anaphylaxis, or any life threatening allergy please contact the Assistant Principal, to ensure the right procedures are in place.

CHILD'S NAME: _____ **GRADE:** _____

ALLERGIC TO: _____

- | | | |
|----|---|--------------------------------------|
| 1. | IS YOUR CHILD UNDER THE CARE OF A PAEDIATRICIAN/ALLERGIST? | YES/NO |
| 2. | DOES YOUR CHILD HAVE A MANAGEMENT PLAN COMPLETED BY A DOCTOR?
If yes please supply. | YES/NO |
| 3. | IS THE ALLERGIC REACTION LIFE THREATENING? | YES/NO |
| 4. | DOES THE ALLERGIC REACTION CAUSE:
a) Difficulty in breathing?
b) Nausea/Vomit?
c) A rash or severe swelling?
d) Other symptoms? | YES/NO
YES/NO
YES/NO
YES/NO |
| 5. | HAS THERE BEEN AN INCREASE IN THE SEVERITY OF THE REACTION WITH SUBSEQUENT
ATTACKS? | YES/NO |
| 6. | DOES THE CHILD HAVE MEDICATION FOR THEIR CONDITION?
Name of Medication _____
Dosage required _____
I HAVE SUPPLIED THE SCHOOL WITH THE ABOVE MEDICATION
DOES THE MEDICATION HAVE TO BE ACCESSIBLE TO THE CHILD AT
ALL TIMES? | YES/NO

YES/NO
YES/NO |

I HEREBY GIVE PERMISSION FOR MY CHILD TO RECEIVE THE ABOVE MEDICATION AT SCHOOL/OUT OF SCHOOL HOURS CARE (please circle) IF REQUIRED.

SIGNED: _____ DATE: _____

IF YOUR CHILD ATTENDS OUT OF SCHOOL HOURS CARE, A COPY OF THIS FORM MUST BE GIVEN TO THEM.

Please remember to supply the appropriate medication and your authority to administer it, to the Out of School Hours care.