



## ANAPHYLAXIS MANAGEMENT PLAN

**This Plan is to be completed by the principal or nominee on the basis of information from the Child's medical practitioner provided by the parent/carer**

School/Center:

Child's name:

Date of birth:

Room/Year level:

Severely allergic to:

Other health conditions:

Medication at school/Center

Parent/cared contact:

Parent/carer information (1)

Parent/carer information (2)

Name:

Name:

Relationship:

Relationship:

Home phone:

Home phone:

Work phone:

Work phone:

Mobile:

Mobile:

Address:

Address

Other emergency contacts  
(if parent/carer not available):

Medical practitioner contact:

Emergency care to be  
Provided at school/Center:

EpiPen® storage:

The following Anaphylaxis Management Plan has been developed with my knowledge and input and will be reviewed on

Signature of parent:

Date:

Signature of principal/Director/nominee:

Date:

