Holy Eucharist Catholic Primary School

FIRST AID

Incorporating: Injury/Treatment/Illness, Asthma, Anaphylaxis and Medical Conditions

APPENDIX:

Holy Eucharist Catholic Primary School Commitment Statement to Child Safety

A safe and nurturing culture for all children and young people at our Catholic school

'The intention for this statement is to provide a central focus for child safety[1] at our Catholic school, built around a common understanding of the moral imperative and overarching commitments that underpin our drive for improvement and cultural change….

…Holy Eucharist Primary School together with the CECV will stay abreast of current legislation and will meet legislative duties to protect the safety and wellbeing of children and young people in our care, including the Victorian Child Safe Standards (Victorian Government 2016), mandatory reporting, grooming, failure to disclose and failure to protect requirements[2]'.

[1]As defined by the Victorian Government Special *Gazette* No. 2 (2016), 'children and young people' in this document refers to those children and young people enrolled as students in Catholic schools in Victoria.
[2]Holy Eucharist Catholic Primary School Commitment Statement to Child Safety

EVIDENCE OF THIS OCCURING AT HOLY EUCHARIST

This evidenced in this policy by:

Holy Eucharist Primary School, together with the guidance of the Catholic Education Commission of Victoria Ltd (CECV) holds the care, safety and wellbeing of children and young people when they are sick or injured regardless of their background or disability. Our utmost responsibility at Holy Eucharist is to create a child-safe school environment.

FIRST AID

Rationale:
Everyone in the Holy Eucharist community has the right to be safe and be treated by qualified first aid people when accident or injury or illness occur.

Aims:
The Policy is required so that all children and Staff at Holy Eucharist School receive the best duty of care in case of illness or accident.

Implementation:
- Teachers who deal with first aid, need to follow the school process.
- Staff who are rostered on first aid must be qualified, with an up to date First Aid Certificate which is paid for by the school.
- Teachers need to document all accidents in the appropriate Children's or Staff Accident Book on computer located in the sick bay.
- A current qualified First Aid person needs to be present on all camps and excursions.
- A Parent or guardian must complete all medical forms, before children can attend camp or an excursion.
- These forms must accompany the teacher on all outings and camps and a copy of camp permission forms must be kept in the office at the time of the camp.
- All teachers on yard duty carry a small bag, containing red cards, tissues, disposable gloves, band-aids, photo cards identifying children with medical needs – pink: children who require an epipen in an emergency, green: children who have seizures, yellow: to alert office staff that someone's needed in an emergency or there is a stranger on the yard.
- Teachers with students who have anaphylaxis in their class to undergo epipen training.
- Office staff to undergo epipen training.
- Document any medicine given out to a child in a medicine book in the sick bay.

Evaluation: To be reviewed annually.

Resources:

School Operations Manual
First Aid Book St John's Ambulance
Asthma Foundation Victoria
Epipen training Manual
The Department of Education and Early Childhood Development
Catholic Education Melbourne

Staff Members involved: Sue Smart
Michael Bonnici (Learning and Teaching/Deputy Principal)

Date of Review: Annually

Updated/Reviewed: 1st December 2017

SCHOOL PROCESSES OF INJURY TREATMENT AND ILLNESS

First Aid Requirements for Staff:

- All classroom teachers must have a Level 2 First aid certificate, which must be renewed every three years.
- A qualified First Aid teacher is timetabled to deal with the injury.
- After assessing the injury, the first-aide person may call for a second opinion from another qualified person.
- The injury is recorded in the Children's Accident Book.

First Aid Treatment: Outside in Yard

• Less serious injuries, such as grazes, small scratches, cuts and blisters can be treated by the teacher on yard duty. Treatment for these injuries: wash under running water and put on band-aid if necessary.

• More serious injuries, such as bumps/lumps on head or other body parts, serious cuts & grazes, eye injuries, bad bruising and bleeding, ***red card*** will be given to injured child, to be treated in the First Aid Room, via the office. If necessary, the parent or the emergency person is called to collect the child and visit the appropriate medical facility.

• Extremely serious injuries, such as suspected fractures, unconsciousness, major multiple injuries, where the child should not be moved. A ***yellow card*** will be sent in to the office by another child asking for help to be sent outside. The parent or the emergency person is called to collect the child and visit the appropriate medical facility.

• Follow the processes on School Action Plans for Anaphylaxis **Pink Card** and Seizures: **Green Card.**

First Aid Treatment: Inside

• If a child is sick within the classroom, the teacher informs the office and sends the sick child and a friend to the office, so that parents can be informed and the child sent home, should the need arise. In extreme cases, the teacher may need to contact the office, in order to stretcher the child out of the classroom. It is suggested that all teachers have a bucket, dustpan, tissues and bum bag containing disposal gloves and band aids within the classroom, in order to deal with minor situations.

• All tissues, band aids etc, need to be disposed of by the person dealing with the injured child, by putting the tainted material in a plastic bag, and tying it securely. This needs to be placed in the appropriate bin as soon as possible. Teachers dealing with any open wounds **MUST** wear disposal gloves at all times.

• All children must be signed out at the office by a parent/guardian if they are going home due to illness.

• A yellow card is to be filled out if there is a serious injury, illness or the child is being sent home.

First Aid Treatment: Out of School Grounds

When teachers leave the school, accompanied by children, they must follow the school policy:

- A first aid kit must accompany the teacher.
- A mobile phone must be accessible
- The medical forms regarding each child in the teachers care.
- Signed consent forms
- Appropriate ratio of adults to children.
- Awareness of children with special medical needs.
- Two adults to accompany the child to hospital, if the need arises.

Updated/Reviewed: 1st December 2017

ASTHMA MANAGEMENT

Rationale:

Asthma affects up to one in four primary school aged children, one in seven teenagers and one in ten adults. It is important therefore for all staff members to be aware of asthma, its symptoms and triggers and the management of asthma in a school environment.

Aims:

To manage asthma and asthma sufferers as effectively and efficiently as possible at school.

Implementation:

- Asthma attach involve the narrowing of airways making it difficult to breathe. Symptoms commonly include difficulty breathing, wheezy breathing, dry and irritating cough, tightness in the chest and difficulty speaking.
- Children and adults with mild asthma rarely require medication however severe asthma sufferers may require daily or additional medication particularly after exercise.
- Professional development will be provided annually for all staff on the nature, prevention and treatment of asthma attacks. Such information will also be displayed around the staffroom.
- All students with asthma must have an up to date (annual) written asthma management plan consistent with Asthma Victoria's requirements completed by their doctor or paediatrician. Appropriate asthma plan proformas are available at www.asthma.org.au
- Asthma plans will be attached to the student records for reference.
- Parents and guardians are responsible for completing accurately the Medical Authority Form and the Asthma Care Plan for Education and Care Services form and to return them to the school without delay.
- Parents and guardians are responsible for ensuring their children have an adequate supply of appropriate asthma medication (including spacer) with them at school at all times.
- The school will provide and have staff trained in the administering of reliever puffers (blue canisters such as Ventolin, Airomir, Asmol or Bricanyl and spacer devices in all first aid kits, including on excursions and camps. Clear written instructions on how to use these medications and devices will be included in each first aid kit, along with steps to be taken to treat severe asthma attacks. Kits will contain 70% alcohol swabs to clean devices after use.
- The first aid staff member will be responsible for checking reliever puffer expiry dates.
- A nebuliser pump will not be used by the school staff unless a student asthma management plan recommends the use of such a device, and only then if the plan includes and complies with section 4.5 7.3 of the SOTF Reference Guide - Asthma Medication Delivery Devices.
- All devices used for the delivery of Asthma medication will be cleaned appropriately after each use. Care must be provided immediately for any student who develops signs of an asthma attack.
- Children suffering asthma attacks should be treated in accordance with their asthma plan.
- If no plan is available children are to be sat down reassured, administered 4 puffs of a shaken reliever puffer (blue canister) delivered via a spacer - inhaling 4 deep breaths per puff, wait 4 minutes, if necessary administer 4 more puffs and repeat the cycle. An ambulance must be called if there is no improvement after the second 4 minute wait period, or if it is the child's first known attack. Parents must be contacted whenever their child suffers an asthma attack.

Frequently Asked Questions and Answers:

Q1: Why has another type of Action Plan been developed?

The Department of Education and Training approached The Asthma Foundation of Victoria to develop a unified Asthma Action Plan for Victorian Schools. Feedback they had been receiving from schools and parents was that there are many different types and formats of Action Plans being provided to schools, and staff members were becoming confused. A lengthy consultation process involving schools from all three school sectors, Government, Catholic and Independent, was undertaken and the Victorian Asthma Action Plans were produced.

Q2: Can schools or parents complete an Asthma Action Plan for their students or children?

No. The Asthma Action Plan for Victoria Schools have been developed as medical documents and must be completed, signed and dated by the patient's medical doctor. If copies are required the original signed copy should be colour photocopied or scanned.

Q3: Is it possible to obtain an electronic copy of the Asthma Action Plan so that the child's information can be inserted by parents or school/childcare staff?
No. The Victorian Asthma Action Plans have been developed in a PDF format to ensure the documents are concise, consistent and easily understood. They now have fields that can be directly typed into by the treating doctor, but not by parents, or school, as they are medical documents.

Q4: How often does an Asthma Action Plan need to be updated?
Asthma Action Plans should be reviewed when patients are reassessed by their doctor, and approximately every 12 months. If there are no changes in diagnosis or management the medical information on the Asthma Action Plan may not need to be updated. However, if the patient is a child, the photo should be updated each time, so they can be easily identified. The Victorian Asthma Action Plan includes the date of next Action Plan review.

Q5: Do I have to complete an Action Plan, if the child only has seasonal asthma, or asthma symptoms when they have a cold?
Yes, any time asthma medication is prescribed and expected to be taken at school or the children's service, it must by law be accompanied by a medical management plan. If the health professional is concerned about diagnosing the child with asthma, it is recommended that they put a shorter review date on the action plan, and write a covering letter to the school or children's service explaining the expected time frame the child will need reliever medication

Evaluation:
This policy will be reviewed as part of the school review cycle

Reviewed: 2017

ANAPHYLAXIS - MANAGEMENT

Rationale:

Anaphylaxis is an acute allergic reaction to certain food items and insect stings. The condition develops in approximately 1-2% of the population. The most common allergens are nuts, eggs, cow's milk and bee or other insect stings, and some medications.

Holy Eucharist School believes that the safety and wellbeing of children who are at risk of anaphylaxis is a whole-of-community responsibility. Holy Eucharist Primary School is committed to:

Aims:

- providing, as far as practicable, a safe and healthy environment in which children at risk of anaphylaxis can participate equally in all aspects of the school's experiences.
- raising awareness about allergies and anaphylaxis amongst all community members. facilitating communication to ensure the safety and wellbeing of children at risk of anaphylaxis.
- actively involving the parents/guardians of each child at risk of anaphylaxis in assessing risks, developing risk minimisation strategies and management strategies for their child.
- ensuring each staff member and other relevant adults have adequate knowledge of allergies, anaphylaxis and emergency procedures.
- ensure that staff members respond appropriately to an anaphylactic reaction by initiating appropriate treatment, including competently administering an EpiPen®.

Implementation:

- Anaphylaxis is a severe and potentially life-threatening condition.
- Signs and symptoms of anaphylaxis include hives/rash, tingling in or around the mouth, abdominal pain, vomiting or diarrhoea, facial swelling, cough or wheeze, difficulty breathing or swallowing, loss of consciousness or collapse, or cessation of breathing.
- Anaphylaxis is best prevented by knowing and avoiding the allergens.
- The Principal alongside the student well-being leader will ensure that an individual management plan is developed, in consultation with the student's parents, for any student who has been diagnosed by a medical practitioner as being at risk of anaphylaxis.
- The individual anaphylaxis management plan will be in place as soon as practicable after the student enrols, and where possible before their first day of school.
- The plan will include an emergency procedures plan (ASCIA Action Plan), provided by the parent, that is signed by the medical practitioner, and sets out the emergency procedures to be taken in the event of an allergic reaction.
- The individual anaphylaxis management plan will also set out the following:
    - Information about the diagnosis, including the type of allergy or allergies the student has (based on a diagnosis from a medical practitioner).
    - Strategies to minimise the risk of exposure to allergens while the student is under the care or supervision of school staff, for in-school and out of school settings including camps and excursions.
- The student's individual management plan will be reviewed, in consultation with the student's parents/ carers:
    - annually, and as applicable,
    - if the student's condition changes, or
    - immediately after a student has an anaphylactic reaction at school.

- It is the responsibility of the parent to:
    - provide the emergency procedures plan (ASCIA Action Plan).
    - inform the school if their child's medical condition changes, and if relevant provide an updated emergency procedures plan (ASCIA Action Plan).
    - Provide an EpiPen or similar as described in ASCIA Plan.

- The Principal will be responsible for ensuring that a communication plan is developed to provide information to all staff, students and parents about anaphylaxis and the school's anaphylaxis management policy.
- The school is responsible for completing the Annual Risk Management Plan which is Reviewed at the start of each year.

- The communication plan will include information about what steps will be taken to respond to an anaphylactic reaction by a student in a classroom, in the school yard, on school excursions, on school camps and special event days.

- Casual relief staff aware of students at risk of anaphylaxis will be informed of students at risk of anaphylaxis and their role in responding to an anaphylactic reaction
- All staff will be anaphylaxis trained and will be briefed once each semester by a staff member who has up to date anaphylaxis management training on:
    - the school's anaphylaxis management policy
    - the causes, symptoms and treatment of anaphylaxis
    - the identities of students diagnosed at risk of anaphylaxis and where their medication is located
    - how to use an auto-adrenaline injecting device (EpiPen)
    - the school's first aid and emergency response procedures
- At other times while the student is under the care or supervision of the school, including excursions, yard duty, camps and special event days, the principal must ensure that there is a sufficient number of staff present who have up to date training in an anaphylaxis management training course.

Evaluation:

- This policy will be reviewed as part of the school's three-year review cycle.

Reference:

- Anaphylaxis Guidelines – A resource for managing severe allergies in government schools
- The Department of Education and Early Childhood Development
- Ministerial Order 706: Anaphylaxis Management in Victorian schools
- Catholic Education Melbourne

Updated/Reviewed: 1st December 2017

MEDICAL CONDITIONS - MANAGEMENT

Rationale:
There needs to be a consistent and ongoing approach to supporting the educational needs of a child with a health condition.
This can best be achieved if parents/guardians work very closely with their child's school. It is important for parents/guardians to organise a meeting with the school principal to outline the expectations and responsibilities of everyone involved.

Implementation:
Students with a medical condition or medication requirements should have a written, medical management plan attached to their personal records. The plan, prepared by the doctor and parents and guardians, should include: brief relevant information concerning the medical condition of the student that will be of assistance to the school Catholic Schools Operational Guide, Catholic Education Commission of Victoria Ltd (CECV) Page 54 of 93 in its care of the student; the type of treatment and the frequency of administering treatment while at school; what action to take if the student's health deteriorates; and the name, address and telephone numbers for emergency doctor and emergency family contact. This includes students at risk of an anaphylactic reaction, and with other serious medical conditions.

Medication and Administration
The school needs to give clear instructions to the parents and guardians as to how it will deal with medication and the dispensing of medication at school. When necessary, the parents and guardians may be requested to obtain written directions from the doctor as to the medication needs of the student while at school. At the beginning of each school year, the parents and guardians should be notified as to procedures that will be followed. When a new student arrives during the year, a part of the information package should have details about medicine, first aid and emergency procedures. Medicines, tablets, topical applications, appliances, etc. should not be kept in a classroom but rather at a designated and securely locked area and placed in a locked container or cupboard. The medication must be clearly identified as to whom it belongs and marked as to the amount of medication and frequency required. It must be in a safe, secure container (e.g. an envelope containing loose tablets is not considered to be a safe and secure container. The original foil pack or part thereof, or the original dispensing container, should be considered to be more secure and reliable as to its contents). The prescription medicine should be that which has been prescribed for the child (and not for another member of the family). It should not be out-of-date and the amount to be dispensed needs to be in accord with directions on the container. Analgesics should only be given with the permission of parents and guardians and be issued by a designated member of staff who should maintain a record to monitor student intake. Such permission should be written and kept in the first aid room.

School Care Program
If your child has high medical needs and is enrolled in a Catholic primary school in Victoria, s/he may be eligible for a service provided in partnership with the Royal Children's Hospital (RCH). The RCH Home and Community Care Service is available to schools upon request through Catholic Education Melbourne.

Emergencies
In cases of emergency or ill health, the school will implement the Medical Management plan and will immediately contact you so you can collect your child or approve the appropriate medical attention. It is important to ensure that your contact details are up to date.

Evaluation:
This policy will be reviewed as part of the school review cycle.

Reference:

Victoria State Government - The Department of Education and Early Childhood Development
Catholic Education Melbourne
The Royal Children's Hospital – Melbourne

Updated/Reviewed: 1st December 2017

Holy Eucharist Catholic Primary School

1a Oleander Drive, St Albans South. VIC 3021

Phone: 8312 0900 Fax: 9366 8192

www.hestalbanssth.catholic.edu.au

MEDICAL SURVEY FOR ALL STUDENTS

Must be completed by a parent/guardian

Name: _____

Class: _____

Date of Birth: _____

Phone Number: _____ **Emergency Number:**_____

Does your child have any of the following medical conditions: *(Please tick)*

	YES	NO	*Please list medication for each.*
Recent operation/injury	☐	☐	_____
Diabetes	☐	☐	_____
Epilepsy/Seizures	☐	☐	_____
Disability	☐	☐	_____
Anaphylaxis (Severe Allergy)	☐	☐	_____
Medication Allergies (e.g. penicillin)	☐	☐	_____
Allergies (Please specify)	☐	☐	_____
Heart Condition/Heart Murmurs	☐	☐	_____
Sinus or Hayfever	☐	☐	_____
Eczema	☐	☐	_____
Marfan	☐	☐	_____
Asthma/Other Respiratory Problems	☐	☐	_____
Other _____ *(Please list)*			_____

Please complete this section if your child has asthma and tick YES or NO

	YES	NO
Does your child use a puffer?	☐	☐
Does your child use Bricanyl Turbuhaler?	☐	☐
Does your child use spacer?	☐	☐

Parent's signature:_____ **Date:** _____

NB: This form must be completed and submitted as soon as possible.

This form does not authorise the school to administer medication.

APPENDIX 2: MEDICATION AUTHORITY FORM

Holy Eucharist Catholic Primary School

1a Oleander Drive, St. Albans VIC 3021
Ph: 8312 0900

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.

****If your child requires different medication or different medication dosage from what is documented on the above two forms, this form needs to be completed.****

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

Name of School: **HOLY EUCHARIST PRIMARY SCHOOL**

Student's Name:_____ Date of Birth:_____ Grade: _____

Address: _____

Medicare No:_____ Health Insurance Name:_____ Policy No_____

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

Ambulance Cover: Yes ☐ No ☐ Membership No:_____

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:

.....

.....

.....

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.

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:
Medical Practitioner's Signature:
Date:
Contact Details:

Name of Parent/ Guardian/Mature Minor:
Signature:
Date:

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

***

Please Note: Mature 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).

APPENDIX 3: INDIVIDUAL MEDICAL MANAGEMENT PLAN *(For all conditions other than anaphylaxis)*

Holy Eucharist Catholic Primary School

1a Oleander Drive St Albans, VIC 3021
Ph: 8312 0900

INDIVIDUAL MEDICAL MANAGEMENT PLAN FOR _____

(Please list Medical Condition)

NB: This form is to be used for <u>all medical conditions</u> including allergies (not asthma or anaphylaxis).
For students with:

- *Asthma - Please complete the Asthma Care Plan*
- *Anaphylaxis – Please complete Individual Anaphylaxis Management Plan*

This plan is to be completed by the Principal or nominee on the basis of information from the student's medical practitioner provided by the Parent.

It is the Parents' responsibility to provide the School with a copy of the student's Medical Action Plan for _____ containing the emergency procedures plan (signed 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 Holy Eucharist School	**Student's Name:**
Student's Date of Birth:	**Student's Year Level:**
Medicare No:	**Health Insurance No:**
Ambulance Cover: ☐ Yes ☐No	**Ambulance Membership No:**

Emergency Contact Details (Parents)

Name		**Name**	
Relationship		**Relationship**	
Home phone		**Home phone**	
Work phone		**Work phone**	
Mobile		**Mobile**	
Address		**Address**	

Emergency Contact Details (An alternative to parents)

Name	
Relationship	
Home phone	
Work phone	
Mobile	

Medical Practitioner

Medical Practitioner Contact:	**Name:**	
	Address:	**Phone**
Please list Medical Plan – this needs to include information for when the child is ill. **(Please attach further information – if needed)**		

Symptoms which may be displayed in the event of an emergency	
Other health issues /conditions	
Is medication needed at school?	
If Yes, what medication is to be given? (Parent will need to fill in Medication Authority Form)	
Doctor Details	Name of Doctor _____ Address _____ Phone _____ Doctor's Signature _____ Date _____

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, 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?**

This individual Medical Management Plan will be reviewed on any of the following occurrences (whichever happens earlier):

- Annually
- if the student's medical condition changes ;
- when the student is to participate in an off-site activity, such as Camps and Out of School Activities (excursions), or at special events conducted, organised or attended by the School (eg. Cultural days, incursions, family fun days)

Parent / Guardian	
I have read, understood and agree with this Medical 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:	

Principal (or nominee)			
I have consulted with the Parents of the student and the relevant School Staff who will be involved in the implementation of this Medical Management Plan.			
Signature of Principal (or nominee)		Date	
Name			

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www.allergy.org.au

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Photo

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: _____

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 ASCIA Action Plans for Anaphylaxis, which include adrenaline (epinephrine) autoinjector instructions

Instructions are also on the device label

Note: All EpiPens should be held in place for 3 seconds regardless of instructions on device label

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 - freeze dry tick and allow to 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

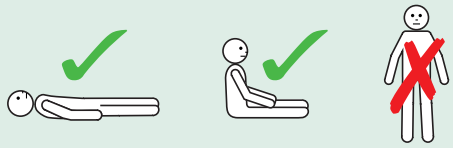
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- 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 (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

© ASCIA 2017 This plan was developed as a medical document that can only be completed and signed by the patient's medical or nurse practitioner and cannot be altered without their permission

APPENDIX 5: TREATMENT PLAN FOR ALLERGIC RHINITIS (Hay Fever)

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www.allergy.org.au

TREATMENT PLAN
Allergic Rhinitis (Hay Fever)

Patient name: _____ **Date:** _____

Plan prepared by: _____ **Signed:** _____

ALLERGEN MINIMISATION

Minimising exposure to confirmed allergen/s may assist to reduce symptoms in some people.
For information go to **www.allergy.org.au/patients/allergy-treatment/allergen-minimisation**

THUNDERSTORM ASTHMA

If pollen allergic, try to stay indoors during thunderstorms in pollen seasons. Use preventer treatments (e.g. intranasal corticosteroid sprays or combined intranasal/antihistamine sprays). Consider allergen immunotherapy (see below). If you also have asthma, use asthma preventers regularly.
For information go to **www.allergy.org.au/patients/asthma-and-allergy/thunderstorm-asthma**

MEDICATIONS

Intranasal corticosteroid spray: _____

1 or 2 times/day/nostril for _____ weeks or _____ months or continuous

Additional instructions: _____

or

Combined intranasal corticosteroid/antihistamine spray: _____

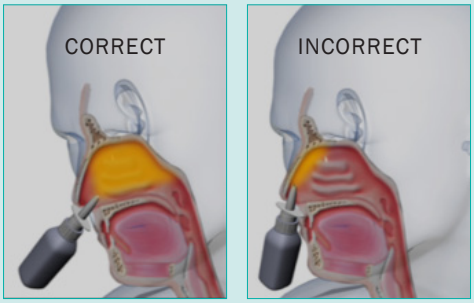
1 or 2 times/day/nostril for _____ weeks or _____ months or continuous

Additional instructions: _____

Note:

- It is important to use these sprays correctly – see instructions below and directions for use.
- Onset of benefit may take days, so these sprays must be used regularly and do not have to be stopped every few weeks.
- If significant pain or bleeding occurs contact your doctor.
- Some treatments mentioned above require a prescription.

1. Prime the spray device according to manufacturer's instructions (for the first time or after a period of non-use).
2. Shake the bottle before each use.
3. Blow nose before spraying if blocked by mucus.
4. Tilt head slightly forward and gently insert nozzle into nostril. Use right hand for left nostril (and left hand for right nostril).
5. Aim the nozzle away from the middle of the nose and direct nozzle into the nasal passage (not upwards towards tip of nose, but in line with the roof of the mouth).
6. Avoid sniffing hard during or after spraying.



Oral non-sedating antihistamine tablet: _____ Dose _____ mL/mg 1 or 2 times/day; or as needed Additional instructions: _____

Intranasal antihistamine sprays: _____ 1 or 2 times/day or as needed

Additional instructions: _____

Saline nasal spray or irrigation _____ _____ times/day or as needed

Use 10 minutes prior if used in conjunction with intranasal corticosteroid spray

Decongestant: _____ nasal spray _____ times/day or tablet

Dose _____ tablets _____ times/day for up to 3 days (not more than 1 course/month)

Other medications: _____

ALLERGEN IMMUNOTHERAPY

If allergen immunotherapy has been initiated by a clinical immunology/allergy specialist, it is important to follow the treatment as prescribed. Contact your doctor if you have any questions or concerns. For information go to **www.allergy.org.au/patients/allergy-treatment/immunotherapy**

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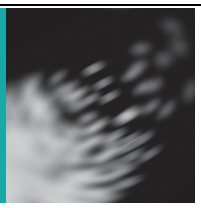
APPENDIX 6: ACTION PLAN FOR ECZEMA

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

ACTION PLAN FOR Eczema



Patient Name: _____ Date of birth: _____

Plan prepared by Doctor: _____ or Nurse Practitioner: _____

Signed: _____ Date: _____

In order to manage your eczema or your child's eczema you should follow all of the selected recommendations below:

ACTION: MAINTAIN AND PROTECT SKIN

Apply _____ **moisturiser at least** _____ **times/day**

Bath/shower with _____ (non-soap based body wash or oil)

Immediately apply _____ moisturiser after bath/shower

Additional bath instructions: _____

Wet dressings: _____ times/day; _____ times/night

ACTION: TREAT FLARE

FACE TREATMENT

Mild to moderate flare of eczema: _____ ointment or cream; 1, 2 or 3 times/day

Severe flare of eczema: _____ ointment or cream; 1, 2 or 3 times/day

Night time application: _____ ointment or cream

BODY TREATMENT

Mild to moderate flare of eczema: _____ ointment or cream; 1, 2 or 3 times/day

Severe flare of eczema: _____ ointment or cream; 1, 2 or 3 times/day

Night time application: _____ ointment or cream

NOTE: Continue to use recommended treatment until skin looks and feels normal, or for _____ days

ACTION: CONTROL ITCH

Cold Compress Specifically designed garments: _____

Antihistamine: _____ Dose: 1, 2 _____ mg tablet or _____ ml; 1 or 2 times/day

Other: _____

ACTION: CONTROL AND PREVENT INFECTION

Bleach baths 1, 2 or 3 times/week:

_____ mls unscented domestic bleach (~4 – 4.5%)/_____ ml water OR

_____ mls unscented domestic bleach in full, or 1/2 bath

Additional instructions: _____

Rinse and immediately apply moisturiser after bleach bath

Nasal ointments: _____ 1, 2 times/day

Treatment oral antibiotic: _____ Dose: 1, 2 _____ mg tablet or _____ ml; _____ times/day for a total of _____ days

Oral antibiotic prophylaxis: _____ Dose: _____ mg tablet or _____ ml; _____ times/day

Varicella vaccination Additional instructions: _____

ACTION: AVOID TRIGGERS AND IRRITANTS

House dust mite

Other confirmed allergens: _____

Soap products including bubble bath

Wool and nylon

Perfumed products

Sand and sand pits

Chlorinated pools

Other irritants: _____

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Holy Eucharist Catholic Primary School
1A Oleander Drive, St Albans South, VIC 3021
Phone: 8312 0900

Australian Children's Education & Care Quality Authority™

Incident, Injury, Trauma and Illness Record/Risk Assessment

(Circle relevant type of record)

Child details

Surname: ..... Given names: .....

Date of birth: ...../...../..... Age: .....

Room/group: .....

Incident/injury/trauma/illness details

Incident/injury/trauma

Circumstances leading to the incident/injury/trauma: .....

.....

.....

Products or structures involved: .....

.....

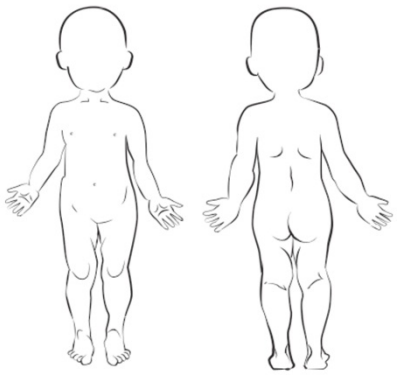
.....

Location: ..... Time: ..... am/pm Date: ...../...../.....

Name of witness: .....

Signature: ..... Date: ...../...../.....

Nature of injury sustained (if applicable):



- o Abrasion, scrape
- o Bite
- o Broken bone / fracture
- o Bruise
- o Burn
- o Concussion
- o Cut
- o Rash
- o Sprain
- o Swelling
- o Other (please specify)

.....

Illness

Circumstances surrounding child becoming ill, including apparent symptoms: .....

.....

.....

.....

.....

Time of illness: ..... am/pm Date of illness: ...../...../.....

Action Taken

Details of action taken, including first aid administration of medication: .....

.....

.....

Medical personnel contacted: Yes / No

If yes, provide details: .....

.....

.....

Details of person completing this record

Name: ..... Signature: .....

Time record was made: ..... am/pm Date record was made ...../...../.....

Notifications (including attempted notifications)

Parent/guardian: ..... Time: ..... am/pm Date: ...../...../.....

Director/teacher/coordinator: ..... Time: ..... am/pm Date: ...../...../.....

Regulatory authority (if applicable): ..... Time: ..... am/pm Date: ...../...../.....

Parental acknowledgement:

I.....

(name of parent/guardian)

have been notified of my child's incident/injury/trauma/illness.

(Please circle)

Signature: ..... Date: ...../...../.....

Additional notes / follow up:

.....

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SOURCE: *http://www.acecqa.gov.au/sample-forms-and-templates-now-available*

Diabetes Management Plan for School

Name of Student:

Date of Birth:

Name of School:

Grade/Year:

Medical Condition: Type 1 diabetes

Insulin Administration: Insulin Pump

Type of Insulin Pump:

Date management plan completed:

Next review date for management plan:

Emergency Contact Details

Contact No.1

Name:

Relationship to student:

Home Number: Mobile Number:

Email Address:

Contact No.2

Name:

Relationship to student:

Home Number: Mobile Number:

Email Address:

Diabetes Health Care Team *(Personnel involved in managing the student's health)*

Hospital/Clinic:

Hospital Phone Number:

Endocrinologist Name:

Diabetes Educator Name:

Emergency Management

Refer to student's individualised ACTION PLAN for treatment in conjunction with the below details.

Hypoglycaemia (Hypo)

A hypo is a low blood glucose level (BGL), occurring when the BGL is less than

Causes: Being physically active, delaying/missing snacks, not eating enough carbohydrate or having too much insulin

Symptoms: Headache, trembling, looking pale, feeling hungry, sweating, lethargy, crying, being irritable, hunger or feeling/acting confused.

Treatment:

Severe Hypo

A sever hypo is when a student has a low blood glucose reading and is not responding.

Causes: Being physically active, delaying/missing snacks, not eating enough carbohydrate or having too much insulin

Symptoms: Extremely drowsy or disorientated and completely refusing food; unconscious or is having a fit/convulsion and unresponsive

Treatment: DO NOT ATTEMPT to give anything by mouth.

1. Lay student on his/her side in the recovery / coma position
2. **Call the ambulance (dial 000) and state it's a DIABETIC EMERGENCY**
3. Contact the parents
4. Stay with student until ambulance arrives

Hyperglycaemia (Hyper)

A hyper is a BGL above

Causes: Not enough insulin administered, eating too many carbs, stress, hormones, weather and physical activity

Symptoms: Drowsy, thirsty, frequent urination, Headache, looking pale, feeling hungry, sweating, lethargy, crying and being irritable

Treatment: If the students BGL is above and is well then no action needed.

If unwell with a high reading, then please contact parents/guardian immediately.

Insulin Administration

The insulin pump continually delivers insulin. The pump will deliver insulin based on carbohydrates eaten and blood glucose level.

Student is able to button push: independently

with supervision

child unable

If with assistance or supervision, the nominated school staff member to assist student is:

If above staff member is away then the nominated staff member to assist is:

Blood Glucose Level (BGL) Testing

Is student able to perform their own BGL Test? Yes

No

If yes, nominated staff member needs to: Remind

Observe

Assist

If no, nominated staff member need to perform BGL check.

The nominated school staff member to assist student is:

If above staff member is away then the nominated staff member to assist is:

Time BGL need to be tested: *(Please Tick)*

	Anytime and anywhere necessary
	Prior to recess or snack
	Prior to lunch
	When hypo suspected
	Prior to activity
	Prior to exam/tests
	When student feels unwell
	Other:

Physical Activity

All students should be encouraged to participate in physical activities, including students living with diabetes. Students should test BGL before sport.

The students BGL needs to be above

If between , student to have 15g of carbohydrate and may commence activity immediately.

If below treat as a hypo before sport. Test 15 minutes later and if within range then student can participate as per usual.

Physical education instructors and sports coaches must have a copy of the action plan and be able to recognize and assist with the treatment of low blood glucose levels.

Please let parent/guardian know blood glucose reading for the day, especially if student has had hypos or hypers.

Camps and Excursions

Notify parents/guardian ahead of the event to ensure further planning is done.

Ensure that action plans are adjusted depending on activity and duration of camp or excursion.

All planning should be in consultation with the student's parent/guardian and if necessary the Diabetes Healthcare Team.

Roles and Responsibilities

Parent/Guardian will:

- Inform the school of their child's condition upon enrolment. If the student is already enrolled, the school should be informed as soon as possible after diagnosis
- Contribute to the development of the school-based diabetes management plan and the action plans
- Ensure the school has the current and appropriate diabetes management plan for their child
- Provide all the equipment the child needs to be safely supported at school which may include medication, blood glucose meter with test strips, insulin pump consumables and hypo treatment foods/drinks
- Provide guidance and support to school staff when concerns or issues arrive with their child's management of diabetes
- Provide consent for the school to contact the appropriately qualified health professionals about their child's condition

School Principals will:

- Co-ordinate a safe and encouraging school environment that:
    - Recognises the student and family are covered under the Disability Discrimination Act and Disability Standard of Education
    - Includes all students with health conditions in school activities
    - Supports students who need supervision or assistance in administrating medication
    - Ensures the student's diabetes management plan is adhered to in the school setting
- Ensure that all staff, including casual staff, are aware of children diagnosed with diabetes, symptoms of low BGL's and the location of medication including the hypo kit.
- Communicate with parents/guardians and health care teams in regards to the student's diabetes management plan in an agreed manner

School Staff will:

- Have a comprehensive understanding of the requirements of the student living with type 1 diabetes in their classroom
- Understand the signs and symptoms of a hypoglycaemic (hypo) and hyperglycaemic (hyper) episode
- Assist the student with diabetes if a hypo or hyper episode occurs and treatment is needed according to the Action Plan
- Support the student living with type 1 diabetes in management of their condition where the child is unable to do so them self. This may include BGL testing and/or administrating insulin

Diabetes Healthcare Team will:

- Assist parents/ guardians and schools in developing a child's individual diabetes management plan
- Provide relevant contact details in case specific questions arise from parents/schools and Diabetes NSW & ACT

The Student will:

- Be permitted to carry they hypo treatment and BGL equipment with them at all times
- Be permitted to have immediate access to water by keeping a water bottle on their desk
- The student shall be permitted to use the bathroom without restriction
- Have open communication with their teacher
- Notify their teacher when they are low or feel unwell
- Do their BGL tests and insulin administration if able to do so
- Bring diabetes supplies to school

Agreements

Parent/Guardian

Name Signature Date

Diabetes Heath Professional

Name Signature Date

Role

School Representative

Name Signature Date

Role

2018 Diabetes School Action Plan

Management Type: INSULIN PUMP

[to be used in conjunction with management plan]

Student Name:

School:

Click to place photograph here

HYPOGLYCAEMIA

LOW Blood Glucose Level

Signs and Symptoms

Symptoms may not always be obvious

DO NOT leave student UNATTENDED
DO NOT delay TREATMENT

Student conscious & cooperative
(Able to eat hypo food)

Hypo Treatment or Fast Acting Carb:
(as supplied or listed on management plan)

Recheck BGL after 15 mins
If BGL repeat fast acting carb

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

First Aid - Place student on their side
Stay with unconscious student

Call an Ambulance Dial 000

Contact Parent or Guardian when safe to do so

Parent / Guardians Name:

Contact No:

The insulin pump continually delivers insulin.

Plus, the pump will deliver insulin based on carbohydrate intake and BGL.

All BGL results must be entered into pump.

Student able to button push:

independently

with supervision

student unable

Routine BGL checking times

- Anytime, anywhere in the school
- Prior to lunch and other times as per management plan
- Any time hypo is suspected or student feels unwell
- Prior to physical activity
- Prior to exams or tests

HYPERGLYCAEMIA

HIGH Blood Glucose Level
(HIGH BGLs are not uncommon)

Signs and Symptoms

There may be no signs and symptoms

Student Well
(Re-check BGL in 2 hours)

Enter BGL in pump, encourage student to drink water & return to class

In 2 hours, if BGL still call parent/ guardian for advice

Student Unwell
(e.g. vomiting)

Contact Parent/ Guardian
to collect student ASAP

Date:

Hospital:

Treating DNE:

Contact No:

diabetes nsw & act | as1diabetes | diabetes victoria

Diabetes Management Plan for School

Name of Student:

Date of Birth:

Name of School:

Grade/Year:

Medical Condition: Type 1 diabetes

Insulin Administration: Multiple Daily Injections

Date management plan completed:

Next review date for management plan:

Emergency Contact Details

Contact No.1

Name:

Relationship to student:

Home Number: Mobile Number:

Email Address:

Contact No.2

Name:

Relationship to student:

Home Number: Mobile Number:

Email Address:

Diabetes Health Care Team *(Personnel involved in managing the student's health)*

Hospital/Clinic:

Hospital Phone Number:

Endocrinologist Name:

Diabetes Educator Name:

Emergency Management

Refer to student's individualised ACTION PLAN for treatment in conjunction with the below details.

Hypoglycaemia (Hypo)

A hypo is a low blood glucose level (BGL), occurring when the BGL is less than

Causes: Being physically active, delaying/missing snacks, not eating enough carbohydrate or having too much insulin

Symptoms: Headache, trembling, looking pale, feeling hungry, sweating, lethargy, crying, being irritable, hunger or feeling/acting confused.

Treatment:

Severe Hypo

A sever hypo is when a student has a low blood glucose reading and is not responding.

Causes: Being physically active, delaying/missing snacks, not eating enough carbohydrate or having too much insulin

Symptoms: Extremely drowsy or disorientated and completely refusing food; unconscious or is having a fit/convulsion and unresponsive

Treatment: DO NOT ATTEMPT to give anything by mouth.

1. Lay student on his/her side in the recovery / coma position
2. **Call the ambulance (dial 000) and state it's a DIABETIC EMERGENCY**
3. Contact the parents
4. Stay with student until ambulance arrives

Hyperglycaemia (Hyper)

A hyper is a BGL above

Causes: Not enough insulin administered, eating too many carbs, stress, hormones, weather and physical activity

Symptoms: Drowsy, thirsty, frequent urination, Headache, looking pale, feeling hungry, sweating, lethargy, crying and being irritable

Treatment: If the students BGL is above and is well then no action needed.

If unwell with a high reading, then please contact parents/guardian immediately.

Insulin Administration

The student requires insulin injections while at school.

Supervision Required: Yes

No

If yes, the nominated school staff member to assist student is:

If above staff member is away then the nominated staff member to assist is:

Type of injection device: Insulin Pen

Syringe

Location where student will administer insulin is:

Time injections need to be had:

Blood Glucose Level (BGL) Testing

Is student able to perform their own BGL Test? Yes

No

If yes, nominated staff member needs to: Remind

Observe

Assist

If no, nominated staff member need to perform BGL check.

The nominated school staff member to assist student is:

If above staff member is away then the nominated staff member to assist is:

Time BGL need to be tested: *(Please Tick)*

	Anytime and anywhere necessary
	Prior to recess or snack
	Prior to lunch
	When hypo suspected
	Prior to activity
	Prior to exam/tests
	When student feels unwell
	Other:

Physical Activity

All students should be encouraged to participate in physical activities, including students living with diabetes. Students should test BGL before sport.

The students BGL needs to be above before sport.

If between , student to have 15g of carbohydrate and may commence activity immediately.

If below treat as a hypo before sport. Test 15 minutes later and if within range then student can participate as per usual.

Physical education instructors and sports coaches must have a copy of the action plan and be able to recognize and assist with the treatment of low blood glucose levels.

Please let parent/guardian know blood glucose reading for the day, especially if student has had hypos or hypers.

Camps and Excursions

Notify parents/guardian ahead of the event to ensure further planning is done.

Ensure that action plans are adjusted depending on activity and duration of camp or excursion.

All planning should be in consultation with the student's parent/guardian and if necessary the Diabetes Healthcare Team.

Roles and Responsibilities

Parent/Guardian will:

- Inform the school of their child's condition upon enrolment. If the student is already enrolled, the school should be informed as soon as possible after diagnosis
- Contribute to the development of the school-based diabetes management plan and the action plans
- Ensure the school has the current and appropriate diabetes management plan for their child
- Provide all the equipment the child needs to be safely supported at school which may include medication, blood glucose meter with test strips, insulin pump consumables and hypo treatment foods/drinks
- Provide guidance and support to school staff when concerns or issues arrive with their child's management of diabetes
- Provide consent for the school to contact the appropriately qualified health professionals about their child's condition

School Principals will:

- Co-ordinate a safe and encouraging school environment that:
    - Recognises the student and family are covered under the Disability Discrimination Act and Disability Standard of Education
    - Includes all students with health conditions in school activities
    - Supports students who need supervision or assistance in administrating medication
    - Ensures the student's diabetes management plan is adhered to in the school setting
- Ensure that all staff, including casual staff, are aware of children diagnosed with diabetes, symptoms of low BGL's and the location of medication including the hypo kit.
- Communicate with parents/guardians and health care teams in regards to the student's diabetes management plan in an agreed manner

School Staff will:

- Have a comprehensive understanding of the requirements of the student living with type 1 diabetes in their classroom
- Understand the signs and symptoms of a hypoglycaemic (hypo) and hyperglycaemic (hyper) episode
- Assist the student with diabetes if a hypo or hyper episode occurs and treatment is needed according to the Action Plan
- Support the student living with type 1 diabetes in management of their condition where the child is unable to do so them self. This may include BGL testing and/or administrating insulin

Diabetes Healthcare Team will:

- Assist parents/ guardians and schools in developing a child's individual diabetes management plan
- Provide relevant contact details in case specific questions arise from parents/schools and Diabetes NSW & ACT

The Student will:

- Be permitted to carry they hypo treatment and BGL equipment with them at all times
- Be permitted to have immediate access to water by keeping a water bottle on their desk
- The student shall be permitted to use the bathroom without restriction
- Have open communication with their teacher
- Notify their teacher when they are low or feel unwell
- Do their BGL tests and insulin administration if able to do so
- Bring diabetes supplies to school

Agreements

Parent/Guardian

Name Signature Date

Diabetes Heath Professional

Name Signature Date

Role

School Representative

Name Signature Date

Role

2018 Diabetes School Action Plan

Management Type: INJECTIONS

[to be used in conjunction with management plan]

Student Name:

School:

Click to place photograph here

Insulin is taken multiple times a day.
An injection will be taken at school: *yes* / *no*

This injection requires:
independently
with supervision
student unable

Injection will be done in:

room/location

Routine BGL checking times

- Anytime, anywhere in the school
- Prior to lunch and other times as per management plan
- Any time hypo is suspected or student feels unwell
- Prior to activity
- Prior to exams or tests

HYPOGLYCAEMIA

LOW Blood Glucose Level

Signs and Symptoms

Symptoms may not always be obvious

DO NOT leave student UNATTENDED
DO NOT delay TREATMENT

Student conscious & cooperative
(Able to eat hypo food)

Hypo Treatment or Fast Acting Carb:
(as supplied or listed on management plan)

Recheck BGL after 15 mins
If BGL repeat fast acting carb

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

First Aid - Place student on their side.
Stay with unconscious student

Call an Ambulance Dial ooo

Contact Parent or Guardian when safe to do so

Parent / Guardians Name:

Contact No:

HYPERGLYCAEMIA

HIGH Blood Glucose Level
(HIGH BGLs are not uncommon)

Signs and Symptoms

There may be no signs and symptoms

Student Well
Re-check BGL in 2 hours

Encourage student to drink water & return to class

In 2 hours, if BGL still call parent/ guardian for advice

Student Unwell
(e.g. vomiting)

Contact Parent/ Guardian
to collect student ASAP

Date:

Hospital:

Treating DNE:

Contact No:

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diabetes nsw & act

as1 diabetes

What is type 1 diabetes?

Type 1 diabetes occurs when the pancreas is unable to make insulin.

Insulin is a hormone that allows glucose from the food we eat to pass from the blood stream into the cells. Our cells need this glucose to provide our bodies with energy.

What are the symptoms?

Being tired

Losing weight

Increased urination

Being thirsty

Dehydration

Tummy pain

What causes type 1 diabetes?

Type 1 diabetes is **not** related to lifestyle or caused by eating too many sweets. It is not possible to catch diabetes from someone else.

Some people carry genes which might make them more likely to get type 1 diabetes.

However, it only develops in these people when something triggers the immune system to destroy the insulin-producing cells in the pancreas.

Type 1 diabetes is managed by:

Insulin delivery (via injections or insulin pump)

Blood glucose tests

Following a healthy eating plan

Being physically active

Regular medical check-ups with diabetes team

For further information contact Diabetes NSW & ACT on 1300 136 588

diabetes nsw & act

as1 diabetes

DIABETES EMERGENCY INFORMATION

1. Watch for symptoms of Hypoglycaemia *(low blood glucose)*

- Sweating
- Weakness
- Inability to think straight
- Paleness
- Changes in mood / behaviour
- Lack of co-ordination
- Trembling
- Weeping
- Drowsiness
- Hunger
- Irritability
- Nausea / stomach cramps

IF IN DOUBT, TREAT!

2. Emergency Action

If the person is conscious, cooperative and has a blood glucose less than 4 mmol/L give any ONE of these:

Fruit juice
(1 small popper or 125-200 ml)

Soft drink containing sugar
(½ can or 125-200ml)

Glucose tablets or glucose gel
(equivalent to 10-15 grams)

Sugar or honey
(2-3 teaspoons)

Jelly Beans
(4 large or 7 small)

3. If the person is unconscious or uncooperative, get emergency help!

Ambulance phone number 000

DIABETES SCHOOL SUPPLY LIST

ITEM	SCHOOL YEAR ( )				
	TERM 1	TERM 2	TERM 3	TERM 4	CAMP
DOCUMENTATION					
Managment Plan					
Action Plan					
Emergency Contact Details					
INSULIN ADMINISTRATION					
Insulin Injections					
Insulin					
Sharps Container					
Insulin Pen/Syringes					
Pen Needles					
Insulin Pump					
Spare Insulin Pump Consumables					
Insulin					
Skin Prep or Alcohol Wipes					
Sharps Container					
Spare Batteries					
Insulin Pen					
BLOOD GLUCOSE LEVEL (BGL) MONITORING					
BGL Meter & Lancing Device					
Test Strips					
Spare Batteries					
Spare Lancets					
Hand Sanitiser or Wipes					
HYPO EMERGENCY KIT					
Hypo Treatment for:					
Office					
Classroom					
Child to carry					
Spare Biscuits or Low GI Food					

Holy Eucharist Catholic Primary School

1a Oleander Drive, St. Albans, VIC 3021

Ph: 8312 0900

ASTHMA CARE PLAN AND PARENTAL CONSENT FOR EDUCATION & CARE SERVICE

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.

PLEASE PRINT CLEARLY **Child's name:** _____ **DOB**_____

Address:_____ **Phone:**_____

Medicare No: _____**Health Insurance Name**_____

Ambulance Cover: ☐Yes ☐No **Ambulance Membership Number**_____

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

_____

Daily asthma management:

This child's usual asthma signs	*Frequency and severity*	*Known triggers for this child's asthma (eg exercise*, colds/flu, smoke) — please detail:*
☐Cough	☐Daily/most days	_____
☐Wheeze	☐Frequently (more than 5 x per year)	_____
☐ Difficulty breathing	☐Occasionally (less than 5 x per year)	_____
☐Other (please describe)	☐Other (please describe)	_____
_____	_____	_____
_____	_____	_____

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

Medication plan

If this child 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	*Parent/Guardian*	*Emergency contact information*
Name of doctor: _____ **Address:** _____ _____ **Phone:** _____ **Signature:** _____ **Date:** _____	*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:** _____	Contact name _____ Phone: _____ Mobile _____ Email _____

APPENDIX 16:

ASTHMA ACTION PLAN – FOR USE WITH A PUFFER *(Health Professional/Doctor to indicate dose)*

Asthma Action Plan

For use with a Puffer

Asthma Foundation VIC

Photo

Name: _____

Date of birth: _____

Confirmed Triggers

Child can self administer if well enough.

Child needs to pre-medicate prior to exercise.

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.

Adrenaline autoinjector prescribed: Y N Type of adrenaline autoinjector: _____

SIGNS AND SYMPTOMS

MILD TO MODERATE

- Minor difficulty breathing
- May have a cough
- May have a wheeze

Other signs to look for:

SEVERE

- Cannot speak a full sentence
- Sitting hunched forward
- Tugging in of skin over chest/throat
- May have a cough or wheeze
- Obvious difficulty breathing
- Lethargic
- Sore tummy (young children)

LIFE-THREATENING

- Unable to speak or 1-2 words
- Collapsed / Exhausted
- Gasping for breath
- May no longer have a cough or wheeze
- Drowsy/ Confused / Unconscious
- Skin discolouration (blue lips)

ASTHMA FIRST AID

For Severe or Life-Threatening signs and symptoms, call for emergency assistance immediately on Triple Zero "000"

Mild to moderate symptoms do not always present before severe or life-threatening symptoms

1. Sit the person upright
   - Stay with the person and be calm and reassuring
2. Give _____ separate puffs of Airomir, Asmol or Ventolin
   - Shake puffer before each puff
   - Get the person to hold their breath for about 5 seconds or as long as comfortably possible.
3. Wait 4 minutes
   - If there is no improvement, repeat step 2
4. If there is still no improvement call emergency assistance
   - Dial Triple Zero "000"
   - Say 'ambulance' and that someone is having an asthma attack
   - Keep giving _____ puffs every 4 minutes until emergency assistance arrives

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

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

- Remove cap from puffer and shake well
- Tilt the chin upward to open the airways, breathe out away from puffer
- Place mouthpiece, between the teeth, and create a seal with lips
- Press once firmly on puffer while breathing in slowly and deeply
- Slip puffer out of mouth
- Hold breath for 5 seconds or as long as comfortable

Emergency Contact Name: _____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Signed: _____

Date prepared: _____

Date of next review: _____

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APPENDIX 17:

ASTHMA ACTION PLAN – FOR USE WITH A PUFFER AND SPACER *(Health Professional/Doctor to indicate dose)*

Asthma Action Plan

For use with a Puffer and Spacer

Photo

Name: _____

Date of birth: _____

Confirmed Triggers

Asthma Foundation VIC

Child can self administer if well enough.

Child needs to pre-medicate prior to exercise.

Face mask needed with spacer

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.

Adrenaline autoinjector prescribed: Y N Type of adrenaline autoinjector: _____

SIGNS AND SYMPTOMS

MILD TO MODERATE

- Minor difficulty breathing
- May have a cough
- May have a wheeze

Other signs to look for:

SEVERE

- Cannot speak a full sentence
- Sitting hunched forward
- Tugging in of skin over chest/throat
- May have a cough or wheeze
- Obvious difficulty breathing
- Lethargic
- Sore tummy (young children)

LIFE-THREATENING

- Unable to speak or 1-2 words
- Collapsed / Exhausted
- Gasping for breath
- May no longer have a cough or wheeze
- Drowsy/ Confused / Unconscious
- Skin discolouration (blue lips)

ASTHMA FIRST AID

For Severe or Life-Threatening signs and symptoms, call for emergency assistance immediately on Triple Zero "000"

Mild to moderate symptoms do not always present before severe or life-threatening symptoms

1. Sit the person upright
   - Stay with the person and be calm and reassuring
2. Give _____ separate puffs of Airomir, Asmol or Ventolin
   - Shake puffer before each puff
   - Put 1 puff into the spacer at a time
   - Take 4 breaths from spacer between each puff
3. Wait 4 minutes
   - If there is no improvement, repeat step 2
4. If there is still no improvement call emergency assistance
   - Dial Triple Zero "000"
   - Say 'ambulance' and that someone is having an asthma attack
   - Keep giving _____ puffs every 4 minutes until emergency assistance arrives

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

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

- Assemble Spacer
- Remove cap from puffer
- Shake puffer well
- Attach puffer to end of spacer
- Place mouthpiece of spacer in mouth and ensure lips seal around it
- Breathe out gently into the spacer
- Press down on puffer canister once to fire medication into spacer
- Breathe in and out normally for 4 breaths (keeping your mouth on the spacer)

Emergency Contact Name: _____

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 prepared: _____

Date of next review: _____

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APPENDIX 18:

ASTHMA ACTION PLAN – FOR USE WITH A BRICANYL TURBUHALER *(Health Professional/Doctor to indicate dose)*

Asthma Action Plan

For use with a Bricanyl Turbuhaler

Asthma Foundation VIC

Photo

Name: _____

Date of birth: _____

Confirmed Triggers

Child can self administer if well enough.

Child needs to pre-medicate prior to exercise.

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.

Adrenaline autoinjector prescribed: Y N Type of adrenaline autoinjector: _____

SIGNS AND SYMPTOMS

MILD TO MODERATE

- Minor difficulty breathing
- May have a cough
- May have a wheeze

Other signs to look for:

SEVERE

- Cannot speak a full sentence
- Sitting hunched forward
- Tugging in of skin over chest/throat
- May have a cough or wheeze
- Obvious difficulty breathing
- Lethargic
- Sore tummy (young children)

LIFE-THREATENING

- Unable to speak or 1-2 words
- Collapsed / Exhausted
- Gasping for breath
- May no longer have a cough or wheeze
- Drowsy/ Confused / Unconscious
- Skin discolouration (blue lips)

ASTHMA FIRST AID

For Severe or Life-Threatening signs and symptoms, call for emergency assistance immediately on Triple Zero "000"

Mild to moderate symptoms do not always present before severe or life-threatening symptoms

1. Sit the person upright
   - Stay with the person and be calm and reassuring
2. Give _____ separate doses of Bricanyl
   - Breathe in through mouth strongly and deeply
   - Remove Turbuhaler from mouth before breathing gently away from the mouthpiece
3. Wait 4 minutes
   - If there is no improvement, give _____ dose of Bricanyl
4. If there is still no improvement call emergency assistance
   - Dial Triple Zero "000"
   - Say 'ambulance' and that someone is having an asthma attack
   - Keep giving _____ dose of Bricanyl every 4 minutes until emergency assistance arrives

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

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

- Unscrew and lift off cap. Hold turbuhaler upright
- Twist blue base around all the way, and then back all the way
- Breathe out gently away from turbuhaler
- Do not breathe in to it
- Put mouthpiece in mouth ensuring a good seal is formed with lips
- Breathe in through mouth strongly and deeply. Remove turbuhaler from mouth
- Hold the breath for about 5 seconds or as long as comfortable. Breathe out

Emergency Contact Name: _____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Signed: _____

Date prepared: _____

Date of next review: _____

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APPENDIX 19:

ASTHMA ACTION PLAN – FOR USE WITH A SYMBICORT RAPIHALER *(Health Professional/Doctor to indicate dose)*

Asthma Action Plan

For use with a Symbicort Rapihaler

Asthma Foundation VIC

Photo

Name: _____

Date of birth: _____

Confirmed Triggers

Child can self administer if well enough.

Child needs to pre-medicate prior to exercise.

Face mask needed with spacer.

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.

Adrenaline autoinjector prescribed: Y N Type of adrenaline autoinjector: _____

SIGNS AND SYMPTOMS

MILD TO MODERATE

- Minor difficulty breathing
- May have a cough
- May have a wheeze

Other signs to look for:

SEVERE

- Cannot speak a full sentence
- Sitting hunched forward
- Tugging in of skin over chest/throat
- May have a cough or wheeze
- Obvious difficulty breathing
- Lethargic
- Sore tummy (young children)

LIFE-THREATENING

- Unable to speak or 1-2 words
- Collapsed / Exhausted
- Gasping for breath
- May no longer have a cough or wheeze
- Drowsy/ Confused / Unconscious
- Skin discolouration (blue lips)

ASTHMA FIRST AID

For Severe or Life-Threatening signs and symptoms, call for emergency assistance immediately on Triple Zero "000"

Mild to moderate symptoms do not always present before severe or life-threatening symptoms

1. Sit the person upright
   - Stay with the person and be calm and reassuring
2. Give _____ separate puffs of Symbicort
   - Shake puffer before each puff
   - Put 1 puff into the spacer at a time
   - Take 4 breaths from spacer between each puff
3. Wait 4 minutes
   - If there is no improvement, give _____ dose of Symbicort
4. If there is still no improvement call emergency assistance
   - Dial Triple Zero "000"
   - Say 'ambulance' and that someone is having an asthma attack
   - Keep giving _____ puffs of Symbicort every 4 minutes until emergency assistance arrives **(maximum 12 doses in total)**

If maximum dose is reached before emergency services arrive follow the 4 x 4 asthma first aid plan on reverse

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

- Assemble Spacer
- Remove cap from puffer
- Shake puffer well
- Attach puffer to end of spacer
- Place mouthpiece of spacer in mouth and ensure lips seal around it
- Breathe out gently into the spacer
- Press down on puffer canister once to fire medication into spacer
- Breathe in and out normally for 4 breaths (keeping your mouth on the spacer)

Emergency Contact Name: _____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Signed: _____

Date prepared: _____

Date of next review: _____

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APPENDIX 20:

ASTHMA ACTION PLAN – FOR USE WITH A SYMBICORT TURBUHALER *(Health Professional/Doctor to indicate dose)*

Asthma Action Plan

For use with a Symbicort Turbuhaler

Photo

Name: _____

Date of birth: _____

Confirmed Triggers

Asthma Foundation VIC

Child can self administer if well enough.

Child needs to pre-medicate prior to exercise.

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.

Adrenaline autoinjector prescribed: Y N Type of adrenaline autoinjector: _____

SIGNS AND SYMPTOMS

MILD TO MODERATE

- Minor difficulty breathing
- May have a cough
- May have a wheeze

Other signs to look for:

SEVERE

- Cannot speak a full sentence
- Sitting hunched forward
- Tugging in of skin over chest/throat
- May have a cough or wheeze
- Obvious difficulty breathing
- Lethargic
- Sore tummy (young children)

LIFE-THREATENING

- Unable to speak or 1-2 words
- Collapsed / Exhausted
- Gasping for breath
- May no longer have a cough or wheeze
- Drowsy/ Confused / Unconscious
- Skin discolouration (blue lips)

ASTHMA FIRST AID

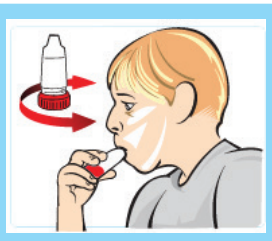
For Severe or Life-Threatening signs and symptoms, call for emergency assistance immediately on Triple Zero "000"

Mild to moderate symptoms do not always present before severe or life-threatening symptoms

1. Sit the person upright
   - Stay with the person and be calm and reassuring
2. Give _____ separate doses of Symbicort
   - Breathe in through mouth strongly and deeply
   - Remove Turbuhaler from mouth before breathing gently away from the mouthpiece
3. Wait 4 minutes
   - If there is no improvement, give _____ dose of Symbicort
4. If there is still no improvement call emergency assistance
   - Dial Triple Zero "000"
   - Say 'ambulance' and that someone is having an asthma attack
   - Keep giving _____ dose of Symbicort every 4 minutes until emergency assistance arrives **(maximum 6 doses in total)**

If maximum dose is reached before emergency services arrive follow the 4 x 4 asthma first aid plan on reverse

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



- Unscrew and lift off cap. Hold turbuhaler upright
- Twist blue base around all the way, and then back all the way
- Breathe out gently away from turbuhaler
- Do not breath in to it
- Put mouthpiece in mouth ensuring a good seal is formed with lips
- Breathe in through mouth strongly and deeply. Remove turbuhaler from mouth
- Hold the breath for about 5 seconds or as long as comfortable. Breathe out

Emergency Contact Name: _____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Signed: _____

Date prepared: _____

Date of next review: _____

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School Camp and Excursion

Asthma Update Form

Asthma Foundation VIC

Name: _____

Date of birth: _____

Confirmed Triggers

Has the student been hospitalized due to asthma, had an acute asthma attack or worsening asthma in the last two weeks? ☐ Yes ☐ No

Has the student's asthma medications changed in the last two weeks? ☐ Yes ☐ No

Is the student well enough to attend camp/excursion? ☐ Yes ☐ No

This form is to be completed by parents/carers of students with asthma prior to an excursion or camp. The form is to be attached to a copy of the student's Asthma Action Plan and brought with students to the camp or excursion. Please provide as much detail as possible.

OTHER MEDICAL CONDITIONS

Has the student had any other illness in the last two weeks? ☐ Yes ☐ No

If YES, please provide details:

Nature of illness? _____ When? _____

Severity? _____ Has this affected their asthma? ☐ Yes ☐ No

ALLERGIC RHINITIS (HAY FEVER)

Does the student hay fever? ☐ Yes ☐ No Does the student have an action plan for hay fever? ☐ Yes ☐ No

Confirmed Triggers for hay fever

Medication ..... **Device** ..... **Dose** ..... **When** .....

Treatment

.....

ADDITIONAL ASTHMA MEDICATION REQUIREMENTS

1. **Medication** ..... **Device** ..... **Dose** ..... **When** .....

   Instructions for use

   .....

2. **Medication** ..... **Device** ..... **Dose** ..... **When** .....

   Instructions for use

   .....

Doctors Name: _____

Phone: _____

Address:

Emergency Contact: _____

Phone: _____

The information provided on this plan is true and correct.

Signed: _____

Date: _____

Additional information:

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Holy Eucharist Catholic Primary School

1A Oleander Drive, St Albans South, VIC 3021

PH 8312 0900

Individual Anaphylaxis Management Plan

This plan is to be completed by the Principal or nominee on the basis of information from the student's medical practitioner (ASCIA Action Plan for Anaphylaxis) provided by the Parent.
It is the Parents' responsibility to provide the School with a copy of the student's ASCIA Action Plan for Anaphylaxis containing the emergency procedures plan (signed 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: HOLY EUCHARIST SCHOOL	**Student's Name**
Student Date of Birth	**Student Year Level**
Medicare No:	**Health Insurance No**
Ambulance Cover: ☐ Yes ☐No	**Ambulance Membership No**
Severely allergic 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

Medical practitioner contact	**Name**	
	Address	**Phone:**
Emergency care to be provided at school		
Storage for Adrenaline Autoinjector (device specific) (EpiPen®/ Anapen®)		

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?

AUTHORISATION

Name of Medical/ Health Practitioner:

Professional Role:

Medical Health Practitioner's Signature:

Date:

Contact Details:

Name of Parent/ Guardian/Mature Minor:

Signature:

Date:

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

ACTION PLAN FOR Anaphylaxis

For EpiPen® adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Photo

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

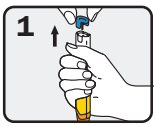
Signed:

_____

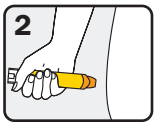
Date: _____

Action Plan due for review: _____

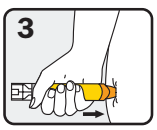
How to give EpiPen®



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®

All EpiPen®s should be held in place for 3 seconds regardless of instructions on device label

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 - freeze dry tick and allow to drop off
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr 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

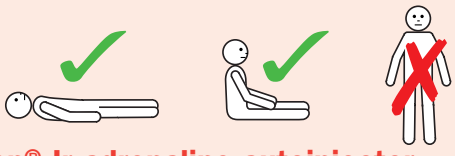
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **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 EpiPen® or EpiPen® Jr 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

© ASCIA 2017 This plan was developed as a medical document that can only be completed and signed by the patient's medical or nurse practitioner and cannot be altered without their permission

This Individual Anaphylaxis Management Plan will be reviewed on any of the following occurrences (whichever happen earlier):

annually;

if the student's medical condition, insofar as it relates to allergy and the potential for anaphylactic reaction, changes ;

as soon as practicable after the student has an anaphylactic reaction at School; and

when the student is to participate in an 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).

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

I consent to the risk minimisation strategies proposed.

Risk minimisation strategies are available at Chapter 8 - Prevention Strategies of the Anaphylaxis Guidelines

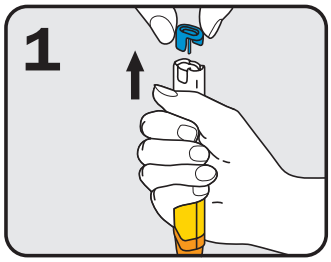
Signature of parent:	
Date:	

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

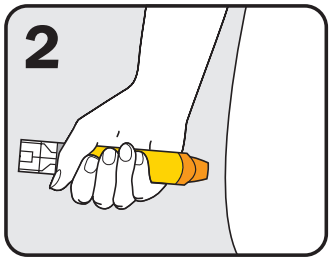
ACTION PLAN FOR Anaphylaxis

For EpiPen® adrenaline (epinephrine) autoinjectors

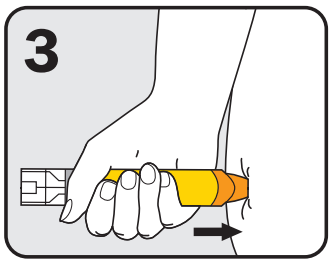
How to give EpiPen®



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®

All EpiPen®s should be held in place for 3 seconds regardless of instructions on device label

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 - freeze dry tick and allow to drop off
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr adrenaline autoinjector
- Phone family/emergency contact

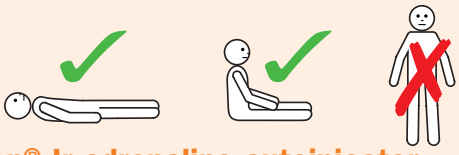
Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

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 EpiPen® or EpiPen® Jr 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

EpiPen® is prescribed for children over 20kg and adults. EpiPen®Jr is prescribed for children 10-20kg

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

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Information
FOR PATIENTS, CONSUMERS AND CARERS

ASCIA Action Plans - frequently asked questions (FAQ)

Q 1: How have the revised ASCIA Action Plans (2017) changed from the previous (2016) versions?

The following revised instructions for EpiPen® and EpiPen® Jr adrenaline (epinephrine) autoinjectors have been included in the 2017 versions of ASCIA Action Plans for Anaphylaxis:

- Reduced injection time from 10 to 3 seconds – this is based on research confirming efficacy and delivery of adrenaline through the 3 second delivery.
- Removal of the massage step after the injection – this has been found to reduce the risk of tissue irritation.

EpiPen®s with the 3 second label will start to enter pharmacies in Australia and New Zealand from 13 June 2017 onwards.

EpiPen®s with a 10 second label can continue to be used and should not be replaced unless they have been used, are just about to expire or have expired.

All EpiPen®s should now be held in place for 3 seconds, regardless of the instructions on the label. However, if they are held for 10 seconds it will not affect the way that the adrenaline works.

To access the 3 second EpiPen® training video, updated ASCIA Action Plans for Anaphylaxis and other resources go to www.allergy.org.au/anaphylaxis

Q 2: How many types of ASCIA Action Plans are there?

There are two types of ASCIA Action Plans for Anaphylaxis (General and Personal):

- The General version (orange) does not contain any personal information and can be used as a poster.
- The Personal version (red) is for individuals who have been prescribed adrenaline autoinjectors. This plan includes personal information and an area for a photo.

There is also an ASCIA Action Plan for Allergic Reactions (green), which is for individuals with medically confirmed mild to moderate allergies, who need to avoid certain allergens, but have not been prescribed adrenaline autoinjectors. This plan includes personal information and an area for a photo.

ASCIA Action Plans for Anaphylaxis and Allergic Reactions have text fields that can be directly typed into.

To save ASCIA Action Plans that have patient details typed into the text fields you need to "save as" and save the document with a new name (e.g. including the patient name). They can then be printed directly from the ASCIA website or the file that they have been saved to. To order hard copies email info@allergy.org.au

Q 3: Can the older versions (prior to 2015) of ASCIA Action Plans still be used?

No. These previous versions of ASCIA Action Plans should no longer be used.

Q 4: Can schools or parents complete an ASCIA Action Plan for Anaphylaxis (personal) or ASCIA Action Plan for Allergic Reactions for their students or children?

No. ASCIA Action Plans have been developed as medical documents and must be completed, signed and dated by the patient's medical doctor. If copies are required the original signed copy should be photocopied or scanned.

Q 5: Is it possible to obtain an electronic copy of the ASCIA Action Plans so that the child's information can be inserted by parents or school/childcare staff?

No. ASCIA Action Plans have been developed in a PDF format to ensure the documents are concise, consistent and easily understood. They now have fields that can be directly typed into by the treating doctor, but not by parents, or school/childcare staff, as they are medical documents.

Q 6: How often does an ASCIA Action Plan need to be updated?

ASCIA Action Plans should be reviewed when patients are reassessed by their doctor, and each time they obtain a new adrenaline autoinjector prescription, which is approximately every 12 to 18 months. If there are no changes in diagnosis or management the medical information on the ASCIA Action Plan may not need to be updated. However, if the patient is a child, the photo should be updated each time, so they can be easily identified.

Q 7: ASCIA Action Plans on the ASCIA website www.allergy.org.au are copyrighted. Can we still print them out and make copies?

Yes. ASCIA Action Plans can be printed off the website or photocopied without infringement of the copyright. ASCIA recommends that the Action Plans are printed in colour, if possible, as they are colour coded.

Q 8: What is the purpose of ASCIA Action Plans for Anaphylaxis?

ASCIA Action Plans for Anaphylaxis provide instructions for first aid treatment of anaphylaxis, to be delivered by people without any special medical training nor equipment, apart from access to an adrenaline autoinjector. All patients who have been prescribed an adrenaline autoinjector should also be provided with an ASCIA Action Plan for Anaphylaxis (personal).

Q 9: Is abdominal pain and/or vomiting without other symptoms a feature of anaphylaxis due to insect allergy?

Yes. The ASCIA Action Plan states that abdominal pain and/or vomiting is a symptom of a mild to moderate allergic reaction unless the individual has been stung or bitten by an insect in which case abdominal pain and/or vomiting is a symptom of anaphylaxis. Therefore, if someone experiences abdominal pain and/or vomiting to a food or medication, this is considered a mild to moderate symptom. However, if someone experiences abdominal pain and/or vomiting after being stung or bitten by an insect, this is a symptom of anaphylaxis and the adrenaline autoinjector should be administered.

It is important to watch for other signs and symptoms.

As stated on the ASCIA Action Plan, if in doubt as to whether the child or adult is experiencing anaphylaxis, give the adrenaline autoinjector and call an ambulance.

Q 10: Why does the ASCIA Action Plan for Anaphylaxis state that CPR should only be given if the person is unresponsive and not breathing normally AFTER giving adrenaline?

Adrenaline is life-saving and must be used promptly. Withholding or delaying the giving of adrenaline can result in deterioration and potentially death of the patient. This is why giving the adrenaline autoinjector is a priority on ASCIA Action Plans for Anaphylaxis, to prevent delays. If CPR is given before this step there is a possibility that adrenaline is delayed or not given. It is important to note that oxygen will usually be administered to the patient by ambulance staff.

Q 11: Who should have an ASCIA Action Plan for Allergic Reactions (green)?

The ASCIA Action Plan for Allergic Reactions has been developed for individuals (children or adults) with a confirmed food, insect or medication allergy, who have not been prescribed an adrenaline autoinjector, as they are not thought to be at risk of anaphylaxis. However, allergies to foods, insects or medications have the potential to result in severe allergic reactions (anaphylaxis) and the ASCIA Action Plan for Allergic Reactions provides guidance for carers on how to manage anaphylaxis if it occurs.

Q 12: Should an individual with allergic rhinitis (hay fever) have an ASCIA Action Plan for Allergic Reactions completed by their doctor?

No. Whilst allergic rhinitis can cause uncomfortable symptoms, these symptoms are not potentially life-threatening allergic reactions and hence an ASCIA Action Plan is not required.

However, if the allergic rhinitis affects an individual's asthma, their Asthma Action Plan should be followed.

Q 13: Is there an ASCIA Treatment Plan specifically designed for individuals with allergic rhinitis (hay fever)?

Yes. The ASCIA Treatment Plan for Allergic Rhinitis has been developed for individuals with allergy to environmental inhalant allergens such as grass pollen, dust mite, or mould, resulting in allergic rhinitis. This Treatment Plan is completed by the individual's medical practitioner and is meant for the individual or the parent and not for schools.

Most schools do not play a role in the treatment and management of allergic rhinitis. However, where medication administration is required at school, parents should liaise directly with the school.

Q 14: Can an organisation obtain an adrenaline autoinjector for general use (not prescribed for an individual) and do they require an Action Plan for Anaphylaxis?

Adrenaline autoinjectors for general use can be purchased without a prescription at full price from pharmacies. More information is available in the ASCIA document "Adrenaline Autoinjectors for General Use" which is available from the Anaphylaxis Resources section on the ASCIA website. The ASCIA Action Plan for Anaphylaxis (general) has been developed for use as a poster or as an instruction guide to include with an adrenaline autoinjector for general use.

Q 15: Where can we go to obtain further resources?

Patient information and anaphylaxis training is available from ASCIA, the peak professional body for clinical immunology and allergy in Australia and New Zealand: www.allergy.org.au/patients

ASCIA INFORMATION FOR PATIENTS, CONSUMERS AND CARERS

Patient information and support is available from the following patient support groups for Australia and New Zealand:

- Allergy & Anaphylaxis Australia: www.allergyfacts.org.au/
- Allergy New Zealand: www.allergy.org.nz/

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ASCIA is the peak professional body of clinical immunology/allergy specialists in Australia and New Zealand

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Disclaimer
This document has been developed and peer reviewed by ASCIA members and is based on expert opinion and the available published literature at the time of review. Information contained in this document is not intended to replace medical advice and any questions regarding a medical diagnosis or treatment should be directed to a medical practitioner. Development of this document is not funded by any commercial sources and is not influenced by commercial organisations.

Content updated 2017

APPENDIX 26: CHANGES TO ANAPHYLAXIS MANAGEMENT FOR ALL SCHOOLS

Department of Education and Early Childhood Development

Changes to Anaphylaxis Management for all Victorian Schools

Issued | February 2014

Ministerial Order 90 has been repealed and will be replaced by Ministerial Order 706 on 22 April 2014. The associated Guidelines in Anaphylaxis Management in schools have also been updated.

All schools (government, Catholic and independent) need to comply with Ministerial Order 706 and the associated Guidelines.

Ministerial Order 706: Anaphylaxis Management in Schools

Key changes to the Ministerial Order include:

- expanded definitions of 'anaphylaxis management training course' and 'school staff'
- a clearer outline of the matters a school's anaphylaxis management policy must contain (clause 6)
- new minimum requirements for all schools to:
  - make a statement in their anaphylaxis management policy that they will comply with the order and guidelines (clause 6, further detail outlined in the Guidelines)
  - develop prevention strategies (clause 8, further detail outlined in the guidelines)
  - the purchase of adrenaline autoinjectors for general use (clause 10)
  - conduct a twice-yearly briefing for relevant school staff on its anaphylaxis management policy and other specified anaphylaxis issues, and
  - complete an Annual Risk Management Checklist (clause 13).
- a new structure and headings
- removal of footnotes (these have been transferred to the updated revised guidelines)

Anaphylaxis Guidelines – A resource for managing severe allergies in Victorian Schools

Key changes to the Guidelines include:

- expanded and amended Glossary of Terms
- consistent language and structural chapter alignment with the Ministerial Order706
- strengthened legal obligations for schools and anaphylaxis management (chapter 4)
- a chapter on the contents of a School Anaphylaxis Management Policy (chapter 6)
- a new requirement for schools to provide a statement that they will comply with the order and guidelines in their policy (chapter 6)
- expanded prevention strategies for schools to consider and plan (chapter 8)
- new information and resource links for schools to access (chapter 11)
- greater clarity on staff training requirements (chapter 12)
- a new School Anaphylaxis Management Policy template (Appendix 2)
- a revised Individual Anaphylaxis Management Plan (Appendix 3)
- a revised Annual Risk Management Checklist (Appendix 4), and
- General updating throughout the document to ensure the guidelines align with the latest medical advice about anaphylaxis.

School Anaphylaxis Management Policy

All schools across Victoria, from 22 April 2014, must by law have an Anaphylaxis Management Policy if they have a student enrolled who has been diagnosed at risk of anaphylaxis. This policy must include procedures for:

- a statement that the School will comply with the Order and guidelines on anaphylaxis management

- a statement that in the event of an anaphylactic reaction, the school's first aid and emergency response procedures and the student's Individual Anaphylaxis Management Plan must be followed
- development and regular review of Individual Anaphylaxis Management Plans for affected students
- prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction
- the purchase of Adrenaline Autoinjectors for General Use by schools
- the development of a Communication Plan
- the training of school staff on anaphylaxis management, and
- the completion of an annual Risk Management Checklist.

Additional Information

- Call the Royal Children's Hospital Anaphylaxis Advisory Line on 1300 725 911 for advice about implementing the requirements of Ministerial Order 706 for all Victorian schools.
- The Department of Education and Early Childhood Development website Anaphylaxis Management in Schools provides a range of support resources including:
  - a Questions and Answers Reference Sheet on school implementation
  - an updated School Anaphylaxis Management Policy template
  - a revised Individual Anaphylaxis Management Plan template
  - an updated Risk Management Checklist template, and
  - an updated PowerPoint presentation to assist schools deliver their twice yearly briefing sessions.

For further information visit:

http://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx

Minister for Education

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GPO BOX 4367
MELBOURNE VICTORIA 3001

School Principal

Dear Principal

The Victorian Government is committed to providing a safe and supportive environment in which children diagnosed at risk of anaphylaxis can participate equally in all aspects of schooling.

On 1 June 2012, the Coroner released findings into the death of a student who died from anaphylaxis after ingesting peanuts. The Department of Education and Early Childhood Development accepted the recommendations and has reviewed its anaphylaxis policy and guidelines.

As a result of this work, I am pleased to announce Ministerial Order 706: Anaphylaxis Management in Victorian schools, which comes into effect on 22 April 2014 and will repeal Ministerial Order 90.

Ministerial Order 706 sets out clearly the steps schools must take to ensure the safety of students at risk of anaphylaxis in their care. These requirements will form the basis of a minimum standard for school registration under Part IV of the Education and Training Reform Act.

All schools across Victoria, from 22 April 2014, must by law have an Anaphylaxis Management Policy if they have a student enrolled who has been diagnosed at risk of anaphylaxis. This policy must include:

- a statement that the school will comply with the Order and guidelines on anaphylaxis management
- a statement that in the event of an anaphylactic reaction, the school's first aid and emergency response procedures and the student's Individual Anaphylaxis Management Plan must be followed
- development and regular review of Individual Anaphylaxis Management Plans for affected students
- prevention strategies to be used by the school to minimise the risk of an anaphylactic reaction
- procedures for the purchase of back up Adrenaline Autoinjectors for General Use by schools
- the development of a Communication Plan
- the training of school staff on anaphylaxis management, and
- the completion of an annual Risk Management Checklist.

State Government Victoria

This original has been printed in black and white on recycled paper to reduce cost and environmental impact.

To support the implementation of Ministerial Order 706, the Department has also revised its Anaphylaxis Guidelines to ensure consistent content and alignment.

To view Ministerial Order 706 and the revised Anaphylaxis Guidelines, please visit the Department's Anaphylaxis Management in Schools website:
www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx

For your reference, please find enclosed a Fact Sheet outlining the key changes to Ministerial Order 706 and the revised Anaphylaxis Guidelines.

The Department's website also has a variety of other resources including:

- a Questions and Answers Fact Sheet
- an updated School Anaphylaxis Management Policy template
- a revised Individual Anaphylaxis Management Plan template
- an updated Risk Management Checklist template
- a list of anaphylaxis training courses that comply with Ministerial Order 706, and
- an updated PowerPoint presentation to assist schools deliver their twice yearly briefing sessions.

Victorian schools are leading the way nationally in providing support to students with severe, life threatening allergies. Our schools are well prepared to support students who have been diagnosed at risk of anaphylaxis. Many schools have excellent strategies and procedures in place in line with the Anaphylaxis Guidelines. These changes will build on this good work.

The key to preventing an anaphylactic incident in schools is knowledge, awareness and planning. I encourage you to revisit the information and resources in the Anaphylaxis Guidelines which contain a range of strategies and advice on anaphylaxis management in schools. It is also important to continue to work in partnership with parents in order to minimise the risks associated with severe allergies.

If school staff require assistance with the implementation or interpretation of Ministerial Order 706 and the revised Anaphylaxis Guidelines, I encourage you to contact the Royal Children's Hospital Anaphylaxis Advisory Line on 1300 725 911.

Yours sincerely

The Hon. Martin Dixon,

MP Minister for Education Encl.

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Information
FOR PATIENTS, CONSUMERS AND CARERS

Travelling with allergy, asthma and anaphylaxis: Checklist

Plan ahead

You may need to request the following from your doctor:

- ☐ Prescriptions to cover your trip.
- ☐ Doctor's letter about the medications you need to take.
- ☐ Special vaccinations.
- ☐ Updated ASCIA Action Plan for Anaphylaxis and ASCIA Travel Plan if you are carrying an adrenaline (epinephrine) autoinjector (e.g. EpiPen). You may wish to photograph these onto your mobile phone together with your prescriptions).
- ☐ Medical report for your travel insurance policy, if required.

Medication

- ☐ Take enough for your trip, plus some spare in case you get delayed, lose it or need a higher dose because of illness (e.g. asthma medicines).
- ☐ Make sure medicines have not expired or will not expire whilst you are travelling.
- ☐ If you have been prescribed an adrenaline autoinjector, you should always carry the devices with you, including when travelling. Factors to be considered when deciding to have more than your usual supply of adrenaline autoinjector devices might include flight duration, destination (e.g. interstate or overseas), and other destination related factors (e.g. English speaking country or not; ability to access medical care; ability to replace the adrenaline autoinjector if used as they are not available in every country; ability to prepare own food or not). Severity related factors should also be considered and all of these issues should be discussed with your doctor, noting that only 2 devices are subsidised by the Australian PBS scheme and that additional devices would have to be purchased at full cost. In New Zealand, adrenaline autoinjectors are not subsidised by Pharmac.
- ☐ Take medication in original packaging. This minimises the risk of having problems with Customs when leaving Australia or New Zealand (there are regulations about exporting government subsidised medicines) or Customs when entering other countries.
- ☐ Carry essential medicines in your hand luggage. Adrenaline autoinjectors should not be packed into checked-in luggage or in overhead lockers. They must be easily accessible at all times.

Vaccination

- ☐ Respiratory infections can worsen asthma. Consider influenza vaccination. If egg allergic, the influenza vaccine can usually be given safely. For more information, go to the health professional information section on the ASCIA website www.allergy.org.au. If you need other egg-containing vaccines, you will need specialist advice.

Travel Plan for Anaphylaxis

- ☐ Download an ASCIA Travel Plan for Anaphylaxis and have it completed by your doctor:

www.allergy.org.au/health-professionals/anaphylaxis-resources/ascia-travel-plan-anaphylaxis
This helps when carrying adrenaline autoinjectors in hand luggage and through Customs.

Notify travel agent and airline/s about food allergy

- ☐ Contact the airline/s to determine their food allergy policies well in advance of travel and before you book tickets.
- ☐ Tell your travel agent and airline/s about your food allergy in advance.

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Insurance

- Have adequate travel insurance.
- Ensure the policy covers your medical condition. Special approval may be required.
- Check if there are any special conditions (e.g. doctor's report required, an additional fee to cover anaphylaxis).

Hospital and other medical facilities

- At your travel destination/s determine the location and contact details of emergency facilities and have these details available in case they are needed.
- Ensure that you have a way of contacting emergency services (e.g. switch your mobile phone to international roaming or purchase local or international SIM cards and check that they work).

Accommodation

- For food allergy, consider self-catering accommodation, which gives you the option of safely preparing food for yourself.
- When booking, enquire about relevant inhalant allergen risk (e.g. pets) if you have significant asthma or allergic rhinitis (hay fever) symptoms.
- Speak with your doctor if you often become unwell when away from home. Some people have medications increased or commenced for the time of the travel.

When boarding (airline, ship)

- Notify ship or airline attendants when you board about your allergies and indicate the location of your ASCIA Action Plan and adrenaline autoinjector (if prescribed).
- If an allergic reaction occurs while travelling, follow your ASCIA Action Plan and notify travel attendants so they can assist if needed.
- You may also wish to notify passengers around you, particularly to reduce the likelihood that food may be offered to young children with food allergy.
- Consider taking your own supply of food, bearing in mind restrictions on liquids for international flights. This is particularly important when considering the bottle size of antihistamine liquid or baby formula.
- Consider wiping down tables and armrests to remove possible residual food allergens (contact can sometimes trigger mild allergic symptoms).
- While fumes or dust from inhaled food allergen might cause allergic rhinitis (hay fever) or mild asthma symptoms, the risks of serious reactions is very low unless the food is actually eaten.
- Some airlines offer "exclusion zones" (not serving allergenic food within a few rows of the allergic person). While this can be requested, availability cannot be guaranteed. Since the effectiveness of 'exclusion zones' has not yet been researched, it is unknown whether this is an effective strategy to reduce the risk of allergen exposure.
- Keep emergency medication with you in hand luggage. If you are travelling with adrenaline autoinjectors, keep these with you or under the seat in front of you and NOT in the overhead locker. You need to be able to access your adrenaline autoinjectors with your seatbelt fastened.

Language cards

- If travelling to non-English speaking countries and eating out, consider purchasing foreign language travel cards that warn about your allergy to show to food service staff.
- Examples include: www.selectwisely.com and www.dietarycard.com

Patient support organisations

You may wish to contact your local patient support organisation for further information and/or resources about travelling with allergies, particularly food allergies. These organisations include:

- Allergy & Anaphylaxis Australia www.allergyfacts.org.au
- Allergy New Zealand www.allergy.org.nz

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www.allergy.org.au

Travel Plan

FOR PEOPLE AT RISK OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

Name: *(as shown on passport)*

Date of birth: _____

Confirmed allergens:

For other details refer to the attached ASCIA Plan for Anaphylaxis

Travel plan prepared by medical or nurse practitioner:

Signed: _____

Date: _____

Additional information:

This person is highly allergic and is at risk of a severe, life threatening allergic reaction (anaphylaxis) if accidentally exposed to the trigger/s which causes their allergic reaction/s.

Because of the potential for anaphylaxis, one or more adrenaline (epinephrine) autoinjectors and a copy of their ASCIA Action Plan for Anaphylaxis should be available and easily accessible at all times for this person while travelling, together with a safe supply of food and liquids appropriate for the travel period.

Administration of an adrenaline autoinjector is the first line treatment for anaphylaxis.

Adrenaline autoinjectors contain a single, fixed dose of adrenaline. In an emergency a person at risk of anaphylaxis requires immediate administration of adrenaline, according to their Action Plan for Anaphylaxis (attached), which can be life saving.

Adrenaline autoinjectors must be carried on all airline flights in hand luggage or on the person.

The luggage hold of an aircraft is NOT an appropriate place for this emergency medication to be stored as the adrenaline autoinjector device:

- needs to be available if required during the flight.
- can be broken with rough handling.
- may be lost if luggage goes astray.
- should not be subjected to temperature fluctuations.

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APPENDIX 30: ANNUAL RISK MANAGEMENT CHECKLIST

Holy Eucharist Catholic Primary School

1A Oleander Drive St Albans South
PH 8312 0900

Annual Risk Management Checklist

(Reviewed August 2016)

General Information	
School name:	
Date of review:	
Who completed this checklist?	Name:
	Position:
Review given to:	Name
	Position
Comments:	

General information	
1. How many current students have been diagnosed as being at risk of anaphylaxis, and have been prescribed an adrenaline autoinjector?	
2. How many of these students carry their adrenaline autoinjector on their person?	
3. Have any students ever had an allergic reaction requiring medical intervention at school?	☐ Yes ☐ No
a. If Yes, how many times?	
4. Have any students ever had an anaphylactic reaction at school?	☐ Yes ☐ No
a. If Yes, how many students?	
b. If Yes, how many times	
5. Has a staff member been required to administer an adrenaline autoinjector to a student?	☐ Yes ☐ No
a. If Yes, how many times?	
6. If your school is a government school, was every incident in which a student suffered an anaphylactic reaction reported via the Incident Reporting and Information System (IRIS)?	☐ Yes ☐ No

Section 1: Training	
7. Have all school staff who conduct classes with students who are at risk of anaphylaxis successfully completed an approved Anaphylaxis Management Training Course, either: • Online training (ASCIA anaphylaxis e-training) within the last 2 years, or • accredited face to face training (22300VIC or 10313NAT) within the last 3 years?	☐ Yes ☐ No
8. Does your school conduct twice yearly briefings annually? If no, please explain why not, as this is a requirement for school registration?	☐ Yes ☐ No
9. Do all school staff participate in a twice yearly briefing? If no, please explain why not, as this is a requirement for school registration?	☐ Yes ☐ No
10. If you are intending to use the ASCIA Anaphylaxis e-training for Victorian Schools: a) Has your school trained a minimum of 2 school staff (School Anaphylaxis Supervisors) to conduct competency checks of adrenaline autoinjectors (EpiPen®)?	☐ Yes ☐ No
b) Are your school staff being assessed for their competency in using adrenaline autoinjectors (EpiPen®) within 30 day of completing the ASCIA Anaphylaxis e-training for Victorian Schools?	☐ Yes ☐ No
SECTION 2: Individual Anaphylaxis Management Plans	
11. Does every student who has been diagnosed as being at risk of anaphylaxis and prescribed an adrenaline autoinjector have an Individual Anaphylaxis Management Plan which includes an ASCIA Action Plan for Anaphylaxis completed and signed by a prescribed medical practitioner?	☐ Yes ☐ No
12. Are all Individual Anaphylaxis Management Plans reviewed regularly with parents (at least annually)?	☐ Yes ☐ No
13. Do the Individual Anaphylaxis Management Plans set out strategies to minimise the risk of exposure to allergens for the following in-school and out of class settings?	
a. During classroom activities, including elective classes	☐ Yes ☐ No
b. In canteens or during lunch or snack times	☐ Yes ☐ No
c. Before and after school, in the school yard and during breaks	☐ Yes ☐ No
d. For special events, such as sports days, class parties and extra-curricular activities	☐ Yes ☐ No
e. For excursions and camps	☐ Yes ☐ No

f. Other	☐ Yes ☐ No
14. Do all students who carry an adrenaline autoinjector on their person have a copy of their ASCIA Action Plan kept at the school (provided by the parent)?	☐ Yes ☐ No
a. Where are the Action Plans kept?	
15. Does the ASCIA Action Plan include a recent photo of the student?	☐ Yes ☐ No
16. Are Individual Management Plans (for students at risk of anaphylaxis) reviewed prior to any off site activities (such as sport, camps or special events), and in consultation with the student's parent/s?	☐ Yes ☐ No
SECTION 3: Storage and accessibility of adrenaline autoinjectors	
17. Where are the student(s) adrenaline autoinjectors stored?	
18. Do all school staff know where the school's adrenaline autoinjectors for general use are stored?	☐ Yes ☐ No
19. Are the adrenaline autoinjectors stored at room temperature (not refrigerated)?	☐ Yes ☐ No
20. Is the storage safe?	☐ Yes ☐ No
21. Is the storage unlocked and accessible to school staff at all times? Comments:	☐ Yes ☐ No
22. Are the adrenaline autoinjectors easy to find? Comments:	☐ Yes ☐ No
23. Is a copy of student's individual ASCIA Action Plan for Anaphylaxis kept together with the student's adrenaline autoinjector?	☐ Yes ☐ No
24. Are the adrenaline autoinjectors and Individual Anaphylaxis Management Plans (including the ASCIA Action Plans) clearly labelled with the student's names?	☐ Yes ☐ No
25. Has someone been designated to check the adrenaline autoinjector expiry dates on a regular basis? Who? ……	☐ Yes ☐ No

26. Are there adrenaline autoinjectors which are currently in the possession of the school and which have expired?	☐ Yes ☐ No
27. Has the school signed up to EpiClub or ANA-alert (optional free reminder services)?	☐ Yes ☐ No
28. Do all school staff know where the adrenaline autoinjectors, the ASCIA Action Plans for Anaphylaxis and the Individual Anaphylaxis Management Plans are stored?	☐ Yes ☐ No
29. Has the school purchased adrenaline autoinjector(s) for general use, and have they been placed in the school's first aid kit(s)?	☐ Yes ☐ No
30. Where are these first aid kits located? Do staff know where they are located?	☐ Yes ☐ No
31. Is the adrenaline autoinjector for general use clearly labelled as the 'General Use' adrenaline autoinjector?	☐ Yes ☐ No
32. Is there a register for signing adrenaline autoinjectors in and out when taken for excursions, camps etc?	☐ Yes ☐ No
SECTION 4: Prevention strategies	
33. Have you done a risk assessment to identify potential accidental exposure to allergens for all students who have been diagnosed as being at risk of anaphylaxis?	☐ Yes ☐ No
34. Have you implemented any of the risk minimisation strategies in the Anaphylaxis Guidelines? If yes, list these in the space provided below. If no please explain why not as this is a requirement for school registration?	☐ Yes ☐ No
35. Are there always sufficient school staff members on yard duty who have current Anaphylaxis Management Training?	☐ Yes ☐ No
SECTION 5: School management and emergency response	
36. Does the school have procedures for emergency responses to anaphylactic reactions? Are they clearly documented and communicated to all staff?	☐ Yes ☐ No
37. Do school staff know when their training needs to be renewed?	☐ Yes ☐ No
38. Have you developed Emergency Response Procedures for when an allergic reaction occurs?	☐ Yes ☐ No
a. In the class room?	☐ Yes ☐ No
b. In the school yard?	☐ Yes ☐ No
c. In all school buildings and sites, including gymnasiums and halls?	☐ Yes ☐ No
d. At school camps and excursions?	☐ Yes ☐ No
e. On special event days (such as sports days) conducted, organised or attended by the school?	☐ Yes ☐ No

39. Does your plan include who will call the ambulance?	☐ Yes ☐ No
40. Is there a designated person who will be sent to collect the student's adrenaline autoinjector and individual ASCIA Action Plan for Anaphylaxis?	☐ Yes ☐ No
41. Have you checked how long it will take to get to the adrenaline autoinjector and corresponding individual ASCIA Action Plan for Anaphylaxis to a student experiencing an anaphylactic reaction from various areas of the school including:	☐ Yes ☐ No
a. The class room?	☐ Yes ☐ No
b. The school yard?	☐ Yes ☐ No
c. The sports field?	☐ Yes ☐ No
d. The school canteen	☐ Yes ☐ No
42. On excursions or other out of school events is there a plan for who is responsible for ensuring the adrenaline autoinjector(s) and Individual Anaphylaxis Management Plans (including the ASCIA Action Plan) and the adrenaline autoinjector for general use are correctly stored and available for use?	☐ Yes ☐ No
43. Who will make these arrangements during excursions? ……	
44. Who will make these arrangements during camps? ……..	
45. Who will make these arrangements during sporting activities? ……..	
46. Is there a process for post incident support in place?	☐ Yes ☐ No
47. Have all school staff who conduct classes attended by students at risk of anaphylaxis, and any other staff identified by the principal, been briefed by someone familiar with the school and who has completed an approved anaphylaxis management course in the last 2 years on:	
a. The school's Anaphylaxis Management Policy?	☐ Yes ☐ No
b. The causes, symptoms and treatment of anaphylaxis?	☐ Yes ☐ No
c. The identities of students at risk of anaphylaxis, and who are prescribed an adrenaline autoinjector, including where their medication is located?	☐ Yes ☐ No
d. How to use an adrenaline autoinjector, including hands on practise with a trainer adrenaline autoinjector?	☐ Yes ☐ No
e. The school's general first aid and emergency response procedures for all in-school and out-of-school environments?	☐ Yes ☐ No
f. Where the adrenaline autoinjector(s) for general use is kept?	☐ Yes ☐ No
g. Where the adrenaline autoinjectors for individual students are located including if they carry it on their person?	☐ Yes ☐ No

SECTION 6: Communication Plan	
48. Is there a Communication Plan in place to provide information about anaphylaxis and the school's policies?	
a. To school staff?	☐ Yes ☐ No
b. To students?	☐ Yes ☐ No
c. To parents?	☐ Yes ☐ No
d. To volunteers?	☐ Yes ☐ No
e. To casual relief staff?	☐ Yes ☐ No
49. Is there a process for distributing this information to the relevant school staff?	☐ Yes ☐ No
a. What is it?	
50. How is this information kept up to date?	
51. Are there strategies in place to increase awareness about severe allergies among students for all in-school and out-of-school environments?	☐ Yes ☐ No
52. What are they?	

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Guidelines

Acute management of anaphylaxis

These guidelines are intended for medical practitioners and nurses providing first responder emergency care. The appendix includes additional information for emergency department staff, ambulance staff, rural or remote medical practitioners and nurses providing emergency care.

Anaphylaxis definitions

- Any **acute onset illness** with **typical skin features** (urticarial rash or erythema/flushing, and/or angioedema), **PLUS** involvement of **respiratory** and/or **cardiovascular** and/or persistent severe **gastrointestinal** symptoms; or
- Any **acute onset** of **hypotension** or **bronchospasm** or **upper airway obstruction** where anaphylaxis is considered possible**, even if typical skin features are not present**.

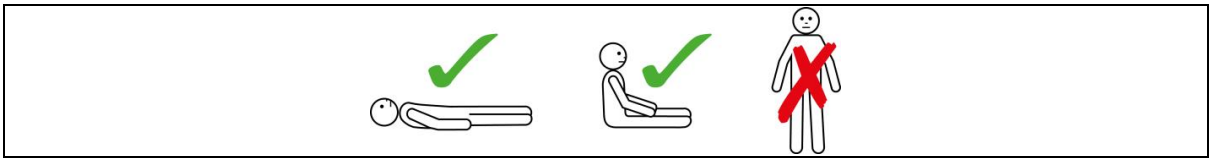
Signs and symptoms of allergic reactions

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

Anaphylaxis - Watch for any one of the following signs:
- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness or collapse
- Pale and floppy (young children)
- Vomiting and/or abdominal pain for insect stings/bites

Immediate actions

1. **Remove allergen** (if still present).
2. **Call for assistance**.
3. **Lay patient flat. Do not allow them to stand or walk.** If breathing is difficult, allow them to sit.



4. **Give INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE (epinephrine)** without delay using an adrenaline autoinjector if available OR adrenaline ampoules and syringe.
5. **Give oxygen** (if available).
6. **Call ambulance** to transport patient if not already in a hospital setting.

ALWAYS give adrenaline autoinjector FIRST, then asthma reliever 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.

- Administer intravenous saline (20mL/kg) if patient is hypotensive (if available).
- If required at any time, commence cardiopulmonary resuscitation (CPR).

For further information about anaphylaxis and to access an ASCIA Action Plan for Anaphylaxis see the ASCIA website www.allergy.org.au/anaphylaxis

Adrenaline administration and dosages

Give INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE (epinephrine) without delay using an adrenaline autoinjector if available OR adrenaline ampoules and syringe, as follows:

- **1:1000 IMI** into outer mid-thigh.
- 0.01mg per kg up to 0.5mg per dose.
- Repeat every 5 minutes as needed.
- If multiple doses required or a severe reaction, consider adrenaline infusion if skills and equipment available.

Adrenaline (epinephrine) dosages chart			
Age (years)	**Weight (kg)**	**Vol. adrenaline 1:1000**	**Adrenaline autoinjector**
<1	5-10	0.05-0.1 mL	
1-2	10	0.1 mL	10-20 kg (~1-5yrs) 0.15mg (green labelled device)
2-3	15	0.15 mL	
4-6	20	0.2 mL	
7-10	30	0.3 mL	>20kg (~>5yrs) 0.3mg (yellow labelled device)
10-12	40	0.4 mL	
>12 and adults*	>50	0.5 mL	

* For pregnant women, a dose of 0.3mg should be used.

Positioning of patient

- Laying the patient flat will improve venous blood return to the heart.
- By contrast, placing the patient in an upright position can impair blood returning to the heart, resulting in insufficient blood for the heart to circulate and low blood pressure.
- The left lateral position is recommended for patients who are pregnant to reduce the risk of compression of the inferior vena cava by the pregnant uterus and thus impairing venous return to the heart.
- Fatality can occur within seconds if a patient stands or sits suddenly.
- For mainly respiratory reactions, the patient may prefer to sit and this may help support breathing and improve ventilation. BEWARE this may trigger hypotension. Monitor closely. Immediately lay the patient flat again, if there is any alteration in conscious state or drop in blood pressure.
- If vomiting, lay the patient on their side (recovery position).
- Patients must **not** be walked to/from the ambulance, even if they appear to have recovered.
- Infographics (see page 1) are included in ASCIA Action Plans to reinforce correct positioning.

Supportive management - when skills and equipment are available

- Check pulse, blood pressure, ECG, pulse oximetry, conscious state.
- Give high flow oxygen if available and airway support if needed.
- Obtain IV access in adults and hypotensive children.
- If hypotensive, give IV normal saline 20mL/kg rapidly and consider additional wide bore IV access.

See Appendix for additional information.

Additional measures - IV adrenaline infusion in clinical setting

If inadequate response or deterioration start IV adrenaline infusion, given by staff who are trained in its use or in liaison with an emergency/critical care specialist.

- Mix 1 mL of 1:1000 adrenaline in 1000 mL of normal saline.
- Start infusion at 5 mL/kg/hour (~0.1 µg/kg/minute).
- Titrate rate up or down according to response.
- Monitor continuously.

IV adrenaline infusions should be used with a dedicated line, infusion pump and anti-reflux valves wherever possible.

CAUTION: IV boluses of adrenaline are NOT recommended as they may increase the risk of cardiac arrhythmia.

Additional measures to consider

For Upper airway obstruction	• Nebulised adrenaline (5mL i.e. 5 ampoules of 1:1000). • Consider need for advanced airway management if skills and equipment are available
For persistent hypotension/ shock	• Give normal saline (maximum of 50mL/kg in first 30 minutes). • Glucagon (1-2mg IMI or IV as starting dose) especially for patients on beta blockers or has heart failure. • In adults, selective vasoconstrictors metaraminol (2-10mg) or vasopressin (10-40 units) only after advice from an emergency medicine/critical care specialist. • See Appendix for additional information
For persistent wheeze	Bronchodilators: • Salbutamol 8 - 12 puffs of 100µg using a spacer OR 5mg salbutamol by nebuliser. • **Note: Bronchodilators do not prevent or relieve upper airway obstruction, hypotension or shock.** Corticosteroids: • Oral prednisolone 1 mg/kg (maximum of 50 mg) or intravenous hydrocortisone 5 mg/kg (maximum of 200 mg). • Note: Steroids must not be used as a first line medication in place of adrenaline.

Antihistamines and corticosteroids

Antihistamines:
- Antihistamines have no role in treating or preventing respiratory or cardiovascular symptoms of anaphylaxis.
- Do not use oral sedating antihistamines as side effects (drowsiness or lethargy) may mimic some signs of anaphylaxis.
- **Injectable promethazine should not be used** in anaphylaxis as it can worsen hypotension and cause muscle necrosis.

Corticosteroids:
- The benefit of corticosteroids in anaphylaxis is unproven.
- It is common practice to prescribe a 2-day course of oral steroids (e.g. oral prednisolone 1 mg/kg, maximum 50 mg daily) to hopefully reduce the risk of symptom recurrence after a severe reaction or a reaction with marked or persistent wheeze.

Observe patient for at least 4 hours after last dose of adrenaline

Relapse, protracted and/or biphasic reactions may occur. Patients require overnight observation if they:
- Had a severe or protracted anaphylaxis (e.g. required repeated doses of adrenaline or IV fluid resuscitation), OR
- Have a history of asthma or severe/protracted anaphylaxis, OR
- Have other concomitant illness (e.g. asthma, history or arrhythmia), OR
- Live alone or are remote from medical care, OR
- Present for medical care late in the evening.

The true incidence of biphasic reactions is estimated to occur following 3-20% of anaphylactic reactions.

Follow up treatment including advice for hospital discharge

Adrenaline autoinjector
- If there is a risk of re-exposure (e.g. stings, foods, unknown cause) then prescribe an adrenaline autoinjector before discharge, pending specialist review.
- Teach the patient how to use the adrenaline autoinjector using a trainer device and provide them with an ASCIA Action Plan for Anaphylaxis - see ASCIA website www.allergy.org.au/anaphylaxis

Allergy specialist referral
- Refer ALL patients who present with anaphylaxis for specialist review
- The allergy specialist will:
  - Identify/confirm cause.
  - Educate regarding avoidance/prevention strategies, management of comorbidities.
  - Provide ASCIA Action Plan for Anaphylaxis - preparation for future reactions.
  - Initiate immunotherapy where available (some insect venoms).

Documentation of episodes
Patients should be advised to document the circumstances of episodes of anaphylaxis to facilitate identification of avoidable causes (e.g. food, medication, herbal remedies, bites and stings, co-factors like exercise) in the 6-8 hours preceding the onset of symptoms.
The ASCIA allergic reactions event record form can be used to collect and document this information.
www.allergy.org.au/health-professionals/anaphylaxis-resources/anaphylaxis-event-record

Preparation: Equipment required for acute management of anaphylaxis

The equipment on your emergency trolley should include:
- Adrenaline 1:1000 (consider adrenaline autoinjector availability in rural locations for initial administration by nursing staff)
- 1ml syringes; 21 gauge needles
- Oxygen
- Airway equipment, including nebuliser and suction
- Defibrillator
- Manual blood pressure cuff
- IV access equipment (including large bore cannulae)
- Pressure sleeve (aids rapid infusion of fluid under pressure)
- At least 3 litres of normal saline

Acknowledgements

The information in these guidelines is consistent with the Australian Prescriber Anaphylaxis Management wall chart www.australianprescriber.com

These guidelines are based on the following international guidelines:
- International Liaison Committee on Resuscitation (ILCOR) and Australian and New Zealand Committee on Resuscitation (ANZCOR) guidelines
- American Academy of Allergy, Asthma and Immunology (AAAAI) anaphylaxis parameter
- World Allergy Organisation (WAO) anaphylaxis guidelines

The appendix includes information on advanced acute management of anaphylaxis for emergency department staff, ambulance staff, rural or remote medical practitioners and nurses providing emergency care. This additional information was previously in a separate document titled ASCIA Guidelines for advanced acute management of anaphylaxis.

Disclaimer

This document has been developed and peer reviewed by ASCIA members and is based on expert opinion and the available published literature at the time of review. Information contained in this document is not intended to replace medical advice and any questions regarding a medical diagnosis or treatment should be directed to a medical practitioner. Development of this document is not funded by any commercial sources and is not influenced by commercial organisations.

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ASCIA is the peak professional body of clinical immunology/allergy specialists in Australia and New Zealand

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Content updated 2017

Appendix

Advanced acute management of anaphylaxis

This additional information is intended for health professionals working in emergency departments, ambulance staff, and rural or remote medical practitioners and nurses providing emergency care.

Supportive management (when skills and equipment available)

- Monitor pulse, blood pressure, respiratory rate, pulse oximetry, conscious state.
- Give high flow oxygen (6-8 L/min) and airway support if needed.
- Supplemental oxygen should be given to all patients with respiratory distress, reduced conscious level and those requiring repeated doses of adrenaline.
- Supplemental oxygen should be considered in patients who have asthma, other chronic respiratory disease, or cardiovascular disease.
- Obtain intravenous (IV) access in adults and in hypotensive children.
- If hypotensive:
  - Give intravenous normal saline (20 mL/kg rapidly under pressure), and repeat bolus if hypotension persists.
  - Consider additional wide bore (14 or 16 gauge for adults) intravenous access.

During severe anaphylaxis with hypotension, marked fluid extravasation into the tissues can occur: DO NOT FORGET FLUID RESUSCITATION.

Assess circulation to reduce risk of overtreatment

- Monitor for signs of overtreatment (especially if respiratory distress or hypotension were absent initially) – including pulmonary oedema, hypertension.
- In this setting (anaphylaxis) it is recommended that if possible a simple palpable systolic blood pressure (SBP) should be measured:
  - Attach a manual BP cuff of an appropriate size and find the brachial or radial pulse.
  - Determine the pressure at which this pulse disappears/reappears (the "palpable" systolic BP).
  - This is a reliable measure of initial severity and response to treatment
  - Measurement of palpable SBP may be more difficult in children.

If a patient is nauseous, shaky, vomiting, or tachycardic but has a normal or elevated SBP, this may be adrenaline toxicity rather than worsening anaphylaxis

Additional measures - IV adrenaline infusion

IV adrenaline infusions should only be given by, or in liaison with, an emergency medicine/critical care specialist.

If your centre has a protocol for IV adrenaline infusion for critical care, this should be utilised and titrated to response with close cardio-respiratory monitoring.

If there is not an established protocol for your centre, two protocols for IV adrenaline infusion are provided, one for pre-hospital settings and a second for emergency departments/tertiary hospital settings only.

It is important to note that the two infusion protocols have *different* concentrations and *different* rates of infusion.

It is vital that IV adrenaline infusions should be used with the following equipment wherever possible:
- Dedicated line,
- Infusion pump,
- Anti-reflux valves in intravenous line.

Additional measures - IV adrenaline infusion for pre-hospital settings

If there is inadequate response to IMI adrenaline or deterioration, start an intravenous adrenaline infusion. IV adrenaline infusions should only be given by, or in liaison with, an emergency medicine/critical care specialist.

The protocol for 1000 mL normal saline is as follows:

- Mix 1 mL of 1:1000 adrenaline in **1000 mL** of normal saline.

- Start infusion at **~5 mL/kg/hour** (~0.1 microgram/kg/minute) using a pump.
  - If you do not have an infusion pump, a standard giving set administers ~20 drops per ml;
  - Therefore, start at ~2 drops per second for an adult.

- Titrate rate up or down according to response and side effects.

- Monitor continuously – ECG and pulse oximetry and frequent non-invasive blood pressure measurements as a minimum to maximise benefit and minimise risk of overtreatment and adrenaline toxicity.

Caution - Intravenous boluses of adrenaline are NOT recommended due to risk of cardiac ischaemia or arrhythmia UNLESS the patient is in cardiac arrest.

Additional measures - IV adrenaline infusion for emergency departments and tertiary hospitals only

This infusion will facilitate a more rapid delivery through a peripheral line and **should only be used in emergency departments and tertiary hospital settings.**

The protocol for 100 mL normal saline is as follows:
- Mix 1 mL of 1:1000 adrenaline in **100 mL** normal saline.
  - Initial rate adjusted accordingly to **0.5 mL/kg/hour**.
  - Should *only* be given by infusion pump.

- Monitor continuously – ECG and pulse oximetry and frequent non-invasive blood pressure measurements as a minimum to maximise benefit and minimise risk of overtreatment and adrenaline toxicity.

Additional measures to consider if IV adrenaline infusion is ineffective

For persistent hypotension/shock

- Give normal saline (maximum of 50mL/kg in first 30 minutes).
- In patients with cardiogenic shock (especially if taking beta blockers) consider an intravenous glucagon bolus of:
  - 1-2mg in adults
  - 20-30 microgram/kg up to 1mg in children

  This may be repeated or followed by an infusion of 1-2mg/hour in adults.
- In adults, selective vasoconstrictors metaraminol (2-10mg) or vasopressin (10-40 units) only after advice from an emergency medicine/critical care specialist. Beware of side effects including arrhythmias, severe hypotension and pulmonary oedema.
- In children, metaraminol 10 micrograms/kg/dose can be used. Noradrenaline infusion may be used in the critical care setting only with invasive blood pressure monitoring.

Advanced airway management

- Oxygenation is more important than intubation *per se*
- Always call for help from the most experienced person available
- If airway support is required, first use the skills you are most familiar with (e.g. jaw thrust, Guedel or nasopharyngeal airway, bag-valve-mask with high flow oxygen attached). This will save most patients, even those with apparent airway swelling (these patients have often stopped breathing due to circulatory collapse rather than airway obstruction and can be adequately ventilated with basic life support procedures)
- DO NOT make prolonged attempts at intubation - remember the patient is not getting any oxygen while you are intubating.

If unable to maintain an airway and the patient's oxygen saturations are falling further approaches to the airway (e.g. cricothyrotomy) should be considered in accordance with established difficult airway management protocols. Specific training is required to perform these procedures.

Special situation: Overwhelming anaphylaxis (cardiac arrest)

Key points:

- Massive vasodilatation and fluid extravasation.
- Unlikely that IMI adrenaline will be absorbed in this situation due to poor peripheral circulation.
- Even if absorbed, IMI adrenaline on its own may be insufficient to overcome vasodilatation and extravasation.
- Need both IV adrenaline bolus (cardiac arrest protocol, 1 mg every 2-3 minutes) AND aggressive fluid resuscitation in addition to CPR (Normal Saline 20mL/kg stat, through a large bore IV under pressure, repeat if no response).
- Do not give up too soon - this is a situation when prolonged CPR should be considered, because the patient arrested rapidly with previously normal tissue oxygenation, and has a potentially reversible cause.

APPENDIX 32: ANAPHYLAXIS GUIDELINES – SAVED ON THE SERVER

VICTORIA State Government | Education and Training

Anaphylaxis Guidelines

A resource for managing severe allergies in Victorian schools

Issued: August 2016

PLEASE FIND ANAPHALAXIS GUIDELINES (82 PAGES) SAVED ON THE SCHOOL SERVER

APPENDIX 33: ASTHMA GUIDELINES – SAVED ON THE SERVER

Asthma Foundation Victoria

Asthma Guidelines

A resource for managing asthma in Victorian schools

Issued: June 2017

PLEASE FIND ASTHMA GUIDELINES (72 PAGES)
SAVED ON THE SCHOOL SERVER