For the latest updates, please refer to this policy which is saved on the server.

Holy Eucharist Catholic Primary School

FIRST AID

Incorporating: Injury/Treatment/Illness, Asthma, Anaphylaxis and Medical Conditions (UPDATED 2020)

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.

For the latest updates, please refer to this policy which is saved on the server.

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: 5th March 2020

For the latest updates, please refer to this policy which is saved on the server.

SCHOOL PROCESSES OF INJURY TREATMENT AND ILLNESS

First Aid Requirements for Staff:

- All classroom teachers must have a valid First aid certificate, which must be renewed every three years.
- A qualified First Aid teacher may be timetabled to deal with injuries.
- After assessing the injury, the first-aide person may call for a second opinion from another qualified person.
- Injuries are recorded in the Children's Accident Book.
- Students who are sent to the Sick Bay need to have their injuries recorded and the type of attention/treatment administered.

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, ***a First Aid Card (green)*** 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 seizures, serious injuries, such as suspected fractures, unconsciousness, major multiple injuries, where the child should not be moved. An ***Emergency Card (red)*** 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.
- Anaphylaxis – Each staff member has a keyring with photos of all anaphylactic students. The students Photo Card is detached from the key ring and is sent to the office via another responsible student. Theoffice staff then take the child's Epipen to the child outside on yard.

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 bag must accompany the teacher.
- A mobile phone must be accessible.
- The medical forms are to accompany the teacher regarding each child in their care.
- All consent forms and Asthma form for camps and Excursions must be filled in and signed.
- 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: 5th March 2020

For the latest updates, please refer to this policy which is saved on the server.

What to do when a child or staff member is injured

PRE

Child/Staff falls and hurts themselves (inside/outside the classroom, excursion/camp)

↓

Contact office and follow appropriate First Aid

↓

Keep the area clear

POST

Child/staff is taken/admitted into hospital (eg broken wrist or needs an operation)

↓

The school needs to contact WorkSafe within 48 hours

↓

A pin number will be issued

↓

Download an 'Accident Report Form' from WorkSafe

↓

Fill in Accident Report Form and keep a copy for the school before submitting to WorkSafe

↓

Attach the report to Catholic Church Insurance (CCI) report

This report should list who has witnessed the accident

↓

Send to CCI

↓

Parents/guardians/staff need to be notified about insurance procedures. Parents/staff can download forms online.

↓

Report the incident to CEM

For the latest updates, please refer to this policy which is saved on the server.

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.

Mandated Asthma Training for Staff

Any staff member who has a direct teaching role with a child who is diagnosed with asthma or any staff member deemed appropriate from a risk management position must complete the free non-accredited training Asthma first aid management for education staff which is offered free of charge by the Asthma Foundation. This certificate is valid for 3 years.

In addition to this any staff member who works directly with a high risk student (diagnosed with severe asthma), any staff responsible for well-being (e.g. school nurse) and any staff member teaching in high risk areas (e.g. physical education) must undertake an accredited course in Management of Asthma Risks and Emergencies in the Workplace or Emergency Asthma Management with an accredited RTO every three years (this certificate is valid for 3 years). Want to hear the good news? You're completing one of those courses right now!!!!

So this is all well and good but hands up if you're worried about forgetting details in that three-year period?? Let's chat through some tips and tricks to keep yourself confident over the next three years and keep the staff in your workplace involved in asthma management . . .

- Hold annual staff briefings to keep everyone in tip-top confidence
- Keep briefing's relevant to your school - review pictures of students diagnosed with asthma and discuss their triggers, year level and risk management plans
- Review where individual children's medication is kept, how to use a puffer and spacer and the location of general asthma emergency kits
- For further tips on holding briefings see: https://asthma.org.au/vic/education-and-training/for-victorian-%20schools/victorian-schools-resources/school-resources

Workplace Asthma Emergency Management Policy

Your school has identified at least one student who is asthmatic. What next?

The first step is to ensure your school has a Workplace Asthma Emergency Management Policy. This policy is developed by the school and outline's the steps the school are taking to identify and manage the risk of an asthma attack occurring - all sounds a bit complicated doesn't it! Let's talk through it.

A Workplace Asthma Emergency Management Policy is basically a plan that you put in place to keep the students at risk of asthma safe. It needs to include (but is not limited to):

- A statement that the school will comply with the school's policy advisory guide for asthma as published by the department
- Identification of school staff who are completing training in asthma response
- Information about the collection, monitoring and regular review of each diagnosed student's individual asthma action plan
- Information and guidance on the school's management of asthma

For the latest updates, please refer to this policy which is saved on the server.

Individual Asthma Risk Minimisation Plans

So, you have multiple kids at school with asthma? It is currently recommended that each individual child has an Asthma Risk Minimisation Plan which includes:

- Their individual Asthma Action Plan
- Triggers
- Strategies to reduce exposure to triggers
- Location of student's medication
- Emergency contact details
- Name of the person(s) responsible for implementing risk minimisation strategies

It is important that these plans are kept in an easily accessible location for staff members and are reviewed annually, if the student's condition changes (e.g. experiences an asthma flare-up) or if they are heading off campus (e.g. camp or excursions).

Risk assessment and emergency management strategies

So, the planning is in place, the first aid kits are stocked with relievers and you know how to administer it. Let's talk about how we can actually minimise the risk of an asthma flare-up happening!

Risk minimisation is one of the most important aspects of the management of asthma and it is everyone's responsibility; parents, students, staff and caregivers. By encouraging risk minimisation, the risk of trigger exposure for student's at risk is reduced.

Risk minimisation should be considered and evaluated in all settings, including:

- Classroom
- Play and common areas
- Canteens
- Sporting facilities
- Excursion locations
- Camp locations
- Before and after school when no-one is on yard duty
- Between classes
- During recess and lunchtimes
- During class time and various class activities

Risk minimisation strategies should be tailored to each individual environment and reviewed annually. Strategies include (but are not limited to):

- Keeping copies of individual student's asthma management plans in the classroom as well as with their asthma inhalers
- Ensuring yard duty staff can identify student's at risk by face
- Keep lawn and clover mowed and in pollen season nominate a staff member to check the pollen count (keeping sensitive students indoors if it is high)
- Perform risk assessments for all out-of-school activities
- Check asthma emergency kits regularly to ensure the inhalers and spacers are in date and safe for use
- Enforce a smoking ban within four metres of the entrance to the school and within school grounds and install 'No Smoking' signs at all entrances
- Consider having only low risk classroom pets such as fish and turtles

Ensure regular cleaning and vacuuming of any surfaces that may collect dust, e.g. carpets and curtains
Storing and Reliever Medication and Asthma Emergency Kits
Reliever medication should be stored in an unlocked, easily accessible, clearly defined place, away from direct light, at room temperature.
Each reliever medication should be clearly labelled with the student's name and be stored with a copy of their individual asthma action plan
General use reliever medication should be clearly labelled and stored with a general use Asthma Action Plan in an Asthma Emergency Kit
Schools should stock at least two Asthma Emergency Kits and an additional kit for every 300 students enrolled
Communication Plans
So how do we make sure everyone has the correct information?

Communication plans on asthma management ensure all school staff, parents and students are informed about asthma and the school's Asthma Management Policy.

Communication plans must include:

- Strategies for staff, parents and students to respond to an asthma flare up in various locations including in-school and out-of-school activity.
- Procedures to inform volunteers and relief staff of students who are at risk of asthma and their role if an asthma flare up occurs
- Arrangements for annual asthma briefing for staff

Incident Reporting / Documentation

Incident reporting and documentation following an asthma emergency must be completed according to individual school incident reporting and documentation policy and procedure.

An incident report should be completed immediately after an asthma event. When completing, ensure you provide as much information as possible such as the patient's condition, signs and symptoms and treatment administered. Ensure all relevant details are provided as this document may be used to determine whether your actions were appropriate.

Evaluation:

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

Reviewed: 10th February 2020

For the latest updates, please refer to this policy which is saved on the server.

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: 5th March 2020

For the latest updates, please refer to this policy which is saved on the server.

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: 5th March 2020

For the latest updates, please refer to this policy which is saved on the server.

Holy Eucharist Catholic Primary School

1a Oleander Drive, St. Albans, Vic 3021

Ph: 8312 0900 Fax: 9366 8192

www.hestalbanssth.catholic.edu.au

MEDICAL SURVEY FOR ALL STUDENTS 2020

Must be completed by a parent/guardian

(Please Print clearly and use BLOCK letters)

Name: *(Students Full Name)* _____

Student Date of Birth: ___/___/_____ Year: _____ Teacher: _____

Name for 1st Contact: _____ Phone Number _____

Name for 2nd Contact: _____ Phone Number _____

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

	YES	NO		YES	NO	*Please list:*
Asthma	☐	☐	Other Respiratory Problems	☐	☐	_____

Please complete this section if your child has asthma and tick

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

Other Medical Conditions:	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	☐	☐	_____
Other _____ *(Please list)*	☐	☐	_____

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

NB: This form must be completed in full.
This form does not authorise the school to administer medication.

APPENDIX 2: MEDICATION AUTHORITY FORM – *Not for students with Asthma or Anaphylaxis*

For the latest updates, please refer to this policy which is saved on the server.

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 by the student's medical/health practitioner, for all medication to be administered at school.

PLEASE NOTE

- **Students with asthma need to have the 'Asthma Care Plan for Education and Care Services' completed instead of this form *(Visit Asthma Australia www.asthma.org.au)***
- **Students with anaphylaxis, an ASCIA *Action Plan for Anaphylaxis* should be completed instead. *(Visit the Australasian Society of Clinical Immunology and Allergy (ASCIA) https://www.allergy.org.au/hp/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).

For the latest updates, please refer to this policy which is saved on the server.

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 all medical conditions 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?

For the latest updates, please refer to this policy which is saved on the server.

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			

APPENDIX 4: ACTION PLAN FOR ALLERGIC REACTIONS **(Green)**

For the latest updates, please refer to this policy which is saved on the server.

ascia
australasian society of clinical immunology and allergy
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 doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises:

- **Medications specified on this plan to be administered according to the plan.**
- **Use of adrenaline autoinjector if available.**
- **Review of this plan is due by the date below.**

Date: _____

Signed: _____

Date: _____

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

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

Instructions are on the device label.

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 7.5-20kg.

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy ☐ seek medical help or ☐ freeze tick and let it drop off
- Stay with person and call for help
- 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

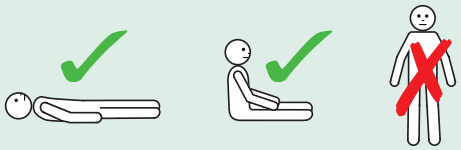
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- **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

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

For the latest updates, please refer to this policy which is saved on the server.

ascia
australasian society of clinical immunology and allergy
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

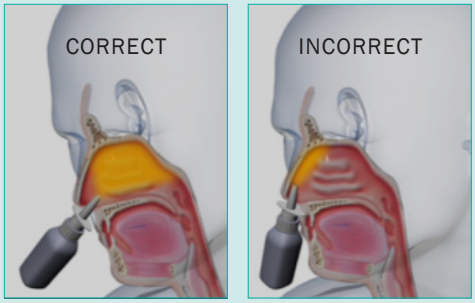
If pollen allergic, try to stay indoors during thunderstorms in pollen seasons. Use preventer treatments (e.g. intranasal corticosteroid sprays or combined intranasal/antihistamine sprays). Consider allergen immunotherapy (see below). If you also have asthma, use asthma preventers regularly.
For information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

APPENDIX 6: ACTION PLAN FOR ECZEMA

For the latest updates, please refer to this policy which is saved on the server.

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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: _____

For the latest updates, please refer to this policy which is saved on the server.

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

Details of person completing this record

Name: ..... Position/role: .....

Date and time record was made ...../...../..... Signature: .....

Child details

Child's full name: .....

Date of birth: ...../...../..... Age: ..... Gender : ☐ Male ☐ Female

Incident details

Incident date: ...../...../..... Time: ..... am/pm Location: .....

Name of witness: .....

Witness signature: ..... Date: ...../...../.....

General activity at the time of **incident/injury/trauma/illness**: .....

.....

.....

Cause of **injury/trauma**: .....

.....

.....

Circumstances surrounding any **illness**, including apparent symptoms: .....

.....

.....

.....

Circumstances if child appeared to be **missing** or otherwise unaccounted for (incl duration, who found child etc): .....

.....

.....

.....

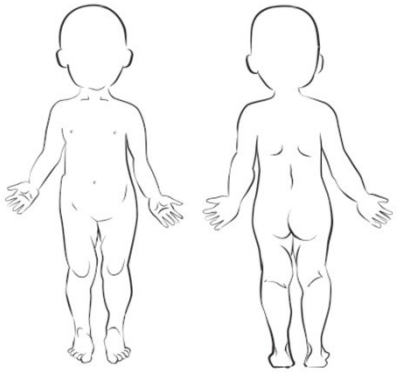
Circumstances if child appeared to have been **taken or removed** from service or was **locked in/out** of service (incl who took the child, duration): .....

.....

.....

Nature of injury/trauma/illness:

Indicate on diagram the part of body affected



- ☐ Abrasion / Scrape
- ☐ Allergic reaction (not anaphylaxis
- ☐ Amputation
- ☐ Anaphylaxis
- ☐ Asthma / respiratory
- ☐ Bite wound
- ☐ Bruise
- ☐ Broken bone / fracture / dislocation
- ☐ Burn / sunburn
- ☐ Choking
- ☐ Concussion
- ☐ Crush / jam
- ☐ Cut / open wound
- ☐ Drowning (non-fatal)
- ☐ Electric shock
- ☐ Eye injury
- ☐ Infectious disease (incl gastrointestinal)
- ☐ High temperature
- ☐ Ingestion / inhalation / insertion
- ☐ Internal injury / Infection
- ☐ Poisoning
- ☐ Rash
- ☐ Respiratory
- ☐ Seizure /unconscious/ convulsion
- ☐ Sprain / swelling
- ☐ Stabbing / piercing
- ☐ Tooth
- ☐ Venomous bite/sting
- ☐ Other (please specify)

.....

Action Taken

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

.....

.....

.....

Did emergency services attend?: Yes / No

Was medical attention sought from a registered practitioner / hospital?: Yes / No

If yes to either of the above, provide details: .....

.....

.....

Have any steps been taken to prevent or minimise this type of incident in the future?: .....

.....

.....

.....

Notifications (including attempted notifications)

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

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

Other agency (if applicable): ..... Time: ..... am/pm Date: ...../...../.....

Regulatory authority (Catholic Education Melbourne): .....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:

.....

.....

.....

.....

.....

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

DIABETES ACTION PLAN 2020 SCHOOL SETTING

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

Twice daily injections

LOW Hypoglycaemia (Hypo)

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

SIGNS AND SYMPTOMS Pale, headache, shaky, sweaty, dizzy, drowsy, changes in behaviour
Note: Symptoms may not always be obvious

DO NOT LEAVE STUDENT ALONE
DO NOT DELAY TREATMENT

MILD

Student conscious
(Able to eat hypo food)

Step1: Give fast acting carbohydrate
e.g. _____
_____

Step 2: Recheck BGL in 15 mins
- If BGL less than 4.0, repeat **Step 1**
- If BGL greater than or equal to 4.0, go to **Step 3**

Step 3: Give sustaining carbohydrate
e.g. _____
_____

SEVERE

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

First Aid DRSABCD
Stay with unconscious student

CALL AN AMBULANCE
DIAL 000

Contact parent/carer when safe to do so

HIGH Hyperglycaemia (Hyper)

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

SIGNS AND SYMPTOMS Increased thirst, extra toilet visits, poor concentration, irritability, tiredness
Note: Symptoms may not always be obvious

Student well
Re-check BGL in 2 hours

Encourage oral fluids, return to activity
1–2 glasses water per hour; extra toilet visits may be required

In 2 hours, if BGL still greater than or equal to 15.0,
CALL PARENT/CARER FOR ADVICE

Student unwell
(eg. vomiting)
- Contact parent/ carer to collect student ASAP
- Check ketones (if able)

KETONES
If unable to contact parent/carer **and** blood ketones greater than or equal to 1.0 mmol/L or dark purple on urine strip

CALL AN AMBULANCE
DIAL 000

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STUDENT'S NAME _____
_____
DATE OF BIRTH GRADE / YEAR
_____
NAME OF SCHOOL
_____
_____

INSULIN will be given before breakfast, at
☐ Home ☐ Before-school care
Please make sure **all** carbohydrate food is eaten at snack and main meal times.

THIS STUDENT IS WEARING
☐ Continuous Glucose Monitoring (CGM)
☐ Flash Glucose Monitoring (FGM)

ROUTINE BGL CHECKING TIMES
These are still required if student is using CGM/FGM
- Anytime, anywhere in the school
- Before main meal
- Anytime hypo is suspected
- Confirm sensor glucose hypo reading
- Before physical education / sport
- Before exams or tests

PHYSICAL EDUCATION / SPORT
- Check BGL before physical education/sport.
- 1 serve of sustaining carbohydrate food before every 30 mins of planned activity.
- Vigorous activity **should not** be undertaken if BGL is greater than or equal to 15.0 **and/or** the student is unwell.

PARENT / CARER NAME _____
CONTACT NO. _____
DIABETES TREATING TEAM _____
CONTACT NO. _____
DATE PLAN CREATED _____

For the latest updates, please refer to this policy which is saved on the server.

Twice daily injections

DIABETES MANAGEMENT PLAN 2020 SCHOOL SETTING

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

STUDENT'S NAME **GRADE / YEAR**

RESPONSIBLE STAFF

School staff who have voluntarily agreed to undertake training and provide support with diabetes care to the student.

STAFF MEMBER	GLUCOSE CHECKING	INSULIN ADMINISTRATION

INSULIN ADMINISTRATION

The student is on two injections of insulin per day. Therefore, ALL carbohydrate food must be eaten at regular times throughout the day.

- The student will have their injections at home.
- The student will require an insulin injection before their breakfast at Before School Care.

BEFORE SCHOOL CARE

Before school care may be provided by the school, or an outside organisation.

Parent/carer to obtain and complete the relevant documentation from this setting, authorising staff to administer/supervise insulin administration to their child.

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

BLOOD GLUCOSE LEVEL (BGL) CHECKING

Target range for blood glucose levels (BGLs): 4 – 7 mmol/L

- BGL results outside of this target range are common.
- BGL check should be done where the student is, whenever needed.
- **The student should always wash and dry their hands before doing the BGL check.**

Blood glucose levels will vary day-to-day and be dependent on a number of factors such as:

- Insulin Dose
- Growth spurts
- Illness / infection
- Excitement / stress
- Type/quantity of food
- Age
- Level of activity

Is the student able to do their own blood glucose check independently?

☐ Yes ☐ No

If NO, the responsible staff member needs to

☐ Do the check ☐ Assist ☐ Observe ☐ Remind

TIMES TO CHECK BGLS (tick all those that apply)

☐ Anytime, anywhere ☐ Before snack ☐ Before lunch
☐ Before activity ☐ Before exams/tests ☐ Beginning of after-school care session
☐ When feeling unwell ☐ Anytime hypo suspected
☐ Other routine times – please specify _____

_____

- Further action is required if BGL is **less than 4.0 mmol/L** or **greater than or equal to 15.0 mmo/L**. Refer to Diabetes Acton Plan.
- If the meter reads '**LO**' this means the BGL is too low to be measured by the meter — follow the hypoglycaemia (Hypo) treatment on Diabetes Action Plan.
- If the meter reads '**HI**' this means the BGL is too high to be measured by the meter — follow hyperglycaemia (Hyper) treatment on Diabetes Action Plan.

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NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

SENSOR GLUCOSE (SG) MONITORING

The student is wearing

- ☐ **Continuous Glucose Monitor (CGM)**
  - ☐ Dexcom G4®
  - ☐ Dexcom G5®
  - ☐ Guardian™ Connect
  - ☐ Guardian™ Sensor 3
- ☐ **Flash Glucose Monitor (FGM)**
  - ☐ Freestyle Libre

- CGM and FGM consist of a small sensor that sits under the skin and measures glucose levels in the fluid surrounding the cells (interstitial fluid).
- These devices are not compulsory management tools.
- With CGM, a transmitter sends data to either a receiver, phone app or insulin pump.
- With FGM, the device will only give a glucose reading when the sensor disc is scanned by a reader or phone app.
- A sensor glucose (SG) reading can differ from a finger prick blood glucose reading during times of rapidly changing glucose levels e.g. eating, after insulin administration, during exercise.
- Therefore, **LOW** or **HIGH** SG readings **must** be confirmed by a finger prick blood glucose check.

Hypo treatment is based on a blood glucose finger prick result.

CGM ALARMS

- CGM alarms may be 'on' or 'off'.
- If 'on' the CGM will alarm if interstitial glucose is low or high.

ACTION: **Check finger prick blood glucose level (BGL) and follow Diabetes Action Plan for treatment.**

- FGM device does not have alarm settings.

USE AT SCHOOL

- Staff are not expected to do more than the current routine diabetes care as per the student's Diabetes Action and Management plans.
- Staff do not need to put CGM apps on their computer, smart phone or carry receivers.
- Parents/carers are the primary contact for any questions regarding CGM/FGM use.
- Some CGM devices can be monitored remotely by family members. They should only contact the school if they foresee a prompt response is required.
- If the sensor/transmitter falls out, staff are required to keep it in a safe place to give to parents/carers.
- The sensor can remain on the student during water activities.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

LOW BLOOD GLUCOSE LEVELS (Hypoglycaemia / Hypo)

Follow the student's Diabetes Action Plan **if BGL less than 4.0 mmol/L**.
Mild hypoglycaemia can be treated by using supplies from the student's HYPO BOX.

HYPO BOX LOCATION/S: _____

HYPO BOX

FAST ACTING CARBOHYDRATE FOOD	AMOUNT TO BE GIVEN

SUSTAINING CARBOHYDRATE FOOD	AMOUNT TO BE GIVEN

- If the student requires more than 2 consecutive fast acting carbohydrate treatments, as per their Diabetes Action Plan, call the student's parent/carer. Continue hypo treatment if needed while awaiting further advice.
- All hypo treatment foods should be provided by the parent/carer.
- Ideally, packaging should be in serve size bags or containers and labelled as **fast acting carbohydrate** food and **sustaining carbohydrate** food.

Mild hypoglycaemia is common.

If the student is having more than 3 episodes of low BGLs at school in a week, make sure that the parent/carer is aware.

SEVERE HYPOGLYCAEMIA (HYPO) MANAGEMENT

Severe hypoglycaemia is not common.

Follow the student's Diabetes Action Plan for any episode of severe hypoglycaemia.

DO NOT attempt to give anything by mouth to the student or rub anything onto the gums as this may lead to choking.

If the school is located more than **30 minutes** from a reliable ambulance service, then staff should discuss Glucagon injection training with the student's Diabetes Treating Team.

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NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

HIGH BLOOD GLUCOSE LEVELS

HIGH BLOOD GLUCOSE LEVELS (Hyperglycaemia / Hyper)

- Although not ideal, BGLs above target range are common.
- **If BGL is 15.0 mmol/L or more**, follow the student's Diabetes Action Plan.
- If the student is experiencing frequent episodes of high BGLs at school, make sure the parent/carer is aware.

KETONES

KETONES

- Ketones occur most commonly when there is not enough insulin in the body.
- Ketones are produced when the body breaks down fat for energy.
- Ketones can be dangerous in high levels.

You will be required to check the student's ketone level if

- Student is unwell **or**
- BGL is above 15.0 mmol/L

☐ Blood ketone check ☐ Urine ketone check

If ketones are **more than 1.0 mmol/L, or dark purple on urine strip**, follow action for ketones on the student's Diabetes Action Plan.

EATING AND DRINKING

EATING AND DRINKING

- The student should not go for longer than 3 hours without eating a carbohydrate meal or snack.
- Younger students will require supervision to ensure all food is eaten.
- The student should not exchange food/meals with another student.
- Seek parent/carer advice regarding appropriate foods for parties/celebrations that are occurring at school.
- Always allow access to drinking water and toilet (high glucose levels can cause increased thirst and extra toilet visits).

Does the student have coeliac disease? ☐ No ☐ Yes*

*Seek parent/carer advice regarding appropriate food and hypo treatments.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

PHYSICAL ACTIVITY

A blood glucose meter and hypo treatment should always be available.

- Check blood glucose level before physical activity.
- Physical activity **may lower** glucose levels.
- The student may require an extra serve of carbohydrate food before every 30 minutes of planned physical activity or swimming as provided in the Activity Food Box.

ACTIVITY FOOD BOX LOCATION: _____

ACTIVITY FOOD BOX

CARBOHYDRATE FOOD TO BE USED	AMOUNT TO BE GIVEN

- Physical activity should not be undertaken **if BGL less than 4.0 mmol/L**. Refer to the Diabetes Action Plan for hypo treatment.
- Vigorous activity **should not** be undertaken **if BGL is greater than or equal to 15.0 mmol/L and/or the student is unwell**.

EXCURSIONS / INCURSIONS

It is important to plan for extracurricular activities.

Consider the following:

- Ensure blood glucose meter, blood glucose strips, ketone strips, hypo and activity food are readily accessible.
- Plan for meal and snack breaks.
- Always have hypo treatment available.

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

CAMPS

CAMPS

It is important to plan for school camps and consider the following:

- Parents/carers need to be informed of any school camps at the **beginning of the year.**
- A separate and specific **Camp Diabetes Management Plan** is required.
- Parents/carers should request a **Camp Diabetes Management Plan** from their Diabetes Treating Team.
- The student's Diabetes Treating Team will prepare the **Camp Diabetes Management Plan** and require at least 4 weeks' notice to do so.
- Parents/carers will need a copy of the camp menu and activity schedule.
- At least 2 responsible staff attending the camp should have a general understanding of type 1 diabetes and the support that the student requires to manage their condition for the duration of the camp.
- If the camp location is more than **30 minutes** from a reliable ambulance service, **Glucagon injection training will be required.**
- School staff will need to discuss any training needs at least 4 weeks before the camp with the student's parents/carers or Diabetes Treating Team.

EXAMS

EXAMS

- BGL should be checked before an exam.
- BGL should be greater than 4.0 mmol/L before exam is started.
- Blood glucose meter, monitoring strips, hypo treatments and water should be available in the exam setting.
- Continuous Glucose Monitoring (CGM) or Flash Glucose Monitoring (FGM) devices and receivers (smart phones) should be available in the exam setting.
- Extra time will be required if a hypo occurs or for toilet privileges.

APPLICATIONS FOR SPECIAL CONSIDERATION

National Assessment Program Literacy and Numeracy (NAPLAN)
Applies to Grade 3, Grade 5, Year 7, Year 9. Check National Assessment Program website – Adjustment for student with disability for further information.

Victorian Certificate of Education (VCE)
Should be lodged at the beginning of Year 11 and 12. Check Victorian Curriculum and Assessment Authority (VCAA) requirements.

NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

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EXTRA SUPPLIES

Provided for diabetes care at the school by parent/carer

- ☐ Insulin and syringes / pens / pen needles
- ☐ Finger prick device
- ☐ Blood glucose meter
- ☐ Blood glucose strips
- ☐ Blood ketone strips
- ☐ Urine ketone strips
- ☐ Sharps container
- ☐ Hypo food
- ☐ Activity food

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

AGREEMENTS

PARENT/CARER

- ☐ I have read, understood and agree with this plan.
- ☐ I give consent to the school to communicate with the Diabetes Treating Team about my child's diabetes management at school.

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

SCHOOL REPRESENTATIVE

- ☐ I have read, understood and agree with this plan.

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

ROLE ☐ Principal ☐ Vice principal

☐ Other (please specify) _____

SIGNATURE _____ DATE _____

DIABETES TREATING MEDICAL TEAM

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

DIABETES ACTION PLAN 2020 SCHOOL SETTING

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

Multiple daily injections

LOW Hypoglycaemia (Hypo)

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

SIGNS AND SYMPTOMS Pale, headache, shaky, sweaty, dizzy, drowsy, changes in behaviour
Note: Symptoms may not always be obvious

DO NOT LEAVE STUDENT ALONE
DO NOT DELAY TREATMENT

MILD

Student conscious
(Able to eat hypo food)

Step1: Give fast acting carbohydrate
e.g.
_____
_____

Step 2: Recheck BGL in 15 mins
- If BGL less than 4.0, repeat **Step 1**
- If BGL greater than or equal to 4.0, go to **Step 3**

Step 3: Give sustaining carbohydrate
e.g.
_____
_____

SEVERE

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

First Aid DRSABCD
Stay with unconscious student

CALL AN AMBULANCE
DIAL 000

Contact parent/carer when safe to do so

HIGH Hyperglycaemia (Hyper)

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

SIGNS AND SYMPTOMS Increased thirst, extra toilet visits, poor concentration, irritability, tiredness
Note: Symptoms may not always be obvious

Student well
Re-check BGL in 2 hours

Encourage oral fluids, return to activity
1–2 glasses water per hour; extra toilet visits may be required

In 2 hours, if BGL still greater than or equal to 15.0,
CALL PARENT/CARER FOR ADVICE

Student unwell
(eg. vomiting)
- Contact parent/ carer to collect student ASAP
- Check ketones (if able)

KETONES

If unable to contact parent/carer **and** blood ketones greater than or equal to 1.0 mmol/L or dark purple on urine strip

CALL AN AMBULANCE
DIAL 000

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STUDENT'S NAME
_____
_____
DATE OF BIRTH GRADE / YEAR
_____
NAME OF SCHOOL
_____
_____

INSULIN is given 4 or more times per day.
An injection will be needed before meals.
Able to inject insulin:
☐ independently ☐ with supervision ☐ with assistance
Injection will be given in: _____ (ROOM/LOCATION)

THIS STUDENT IS WEARING
☐ Continuous Glucose Monitoring (CGM)
☐ Flash Glucose Monitoring (FGM)

ROUTINE BGL CHECKING TIMES
These are still required if student is using CGM/FGM
- Anytime, anywhere in the school
- Before main meal
- Anytime hypo is suspected
- Confirm sensor glucose hypo reading
- Before physical education / sport
- Before exams or tests

PHYSICAL EDUCATION / SPORT
- Check BGL before physical education/sport.
- 1 serve of sustaining carbohydrate food before every 30 mins of planned activity.
- Vigorous activity **should not** be undertaken if BGL is greater than or equal to 15.0 **and/or** the student is unwell.

PARENT / CARER NAME _____
CONTACT NO. _____
DIABETES TREATING TEAM _____
CONTACT NO. _____
DATE PLAN CREATED _____

For the latest updates, please refer to this policy which is saved on the server.

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

STUDENT'S NAME **GRADE / YEAR**

RESPONSIBLE STAFF

School staff who have voluntarily agreed to undertake training and provide support with diabetes care to the student.

STAFF MEMBER	GLUCOSE CHECKING	INSULIN ADMINISTRATION

INSULIN ADMINISTRATION

The student requires an injection of insulin at lunchtime.

Is supervision required? ☐ Yes ☐ No

If yes, the responsible staff need to:

☐ Remind ☐ Observe ☐ Assist

☐ Administer injection (Dose as per additional documentation provided)

Responsible staff will need to receive training on how to administer insulin injections.

Type of injection device: ☐ Pen ☐ Syringe

The location in the school where the injection is to be given:

A Medication Authority Form is required if school staff are required to administer / supervise insulin.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

BLOOD GLUCOSE LEVEL (BGL) CHECKING

Target range for blood glucose levels (BGLs): 4 – 7 mmol/L

- BGL results outside of this target range are common.
- BGL check should be done where the student is, whenever needed.
- **The student should always wash and dry their hands before doing the BGL check.**

Blood glucose levels will vary day-to-day and be dependent on a number of factors such as:

- Insulin Dose
- Excitement / stress
- Age
- Growth spurts
- Type/quantity of food
- Level of activity
- Illness / infection

Is the student able to do their own blood glucose check independently?

☐ Yes ☐ No

If NO, the responsible staff member needs to

☐ Do the check ☐ Assist ☐ Observe ☐ Remind

TIMES TO CHECK BGLS (tick all those that apply)

☐ Anytime, anywhere ☐ Before snack ☐ Before lunch
☐ Before activity ☐ Before exams/tests ☐ Beginning of after-school care session
☐ When feeling unwell ☐ Anytime hypo suspected
☐ Other routine times – please specify _____

_____

- Further action is required if BGL is **less than 4.0 mmol/L** or **greater than or equal to 15.0 mmo/L**. Refer to Diabetes Acton Plan.
- If the meter reads '**LO**' this means the BGL is too low to be measured by the meter — follow the hypoglycaemia (Hypo) treatment on Diabetes Action Plan.
- If the meter reads '**HI**' this means the BGL is too high to be measured by the meter — follow hyperglycaemia (Hyper) treatment on Diabetes Action Plan.

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NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

SENSOR GLUCOSE (SG) MONITORING

The student is wearing

- ☐ **Continuous Glucose Monitor (CGM)**
  - ☐ Dexcom G4®
  - ☐ Dexcom G5®
  - ☐ Guardian™ Connect
  - ☐ Guardian™ Sensor 3
- ☐ **Flash Glucose Monitor (FGM)**
  - ☐ Freestyle Libre

- CGM and FGM consist of a small sensor that sits under the skin and measures glucose levels in the fluid surrounding the cells (interstitial fluid).
- These devices are not compulsory management tools.
- With CGM, a transmitter sends data to either a receiver, phone app or insulin pump.
- With FGM, the device will only give a glucose reading when the sensor disc is scanned by a reader or phone app.
- A sensor glucose (SG) reading can differ from a finger prick blood glucose reading during times of rapidly changing glucose levels e.g. eating, after insulin administration, during exercise.
- Therefore, **LOW** or **HIGH** SG readings **must** be confirmed by a finger prick blood glucose check.

Hypo treatment is based on a blood glucose finger prick result.

CGM ALARMS

- CGM alarms may be 'on' or 'off'.
- If 'on' the CGM will alarm if interstitial glucose is low or high.

ACTION: **Check finger prick blood glucose level (BGL) and follow Diabetes Action Plan for treatment.**

- FGM device does not have alarm settings.

USE AT SCHOOL

- Staff are not expected to do more than the current routine diabetes care as per the student's Diabetes Action and Management plans.
- Staff do not need to put CGM apps on their computer, smart phone or carry receivers.
- Parents/carers are the primary contact for any questions regarding CGM/FGM use.
- Some CGM devices can be monitored remotely by family members. They should only contact the school if they foresee a prompt response is required.
- If the sensor/transmitter falls out, staff are required to keep it in a safe place to give to parents/carers.
- The sensor can remain on the student during water activities.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

LOW BLOOD GLUCOSE LEVELS (Hypoglycaemia / Hypo)

Follow the student's Diabetes Action Plan **if BGL less than 4.0 mmol/L**.
Mild hypoglycaemia can be treated by using supplies from the student's HYPO BOX.

HYPO BOX LOCATION/S: _____

HYPO BOX

FAST ACTING CARBOHYDRATE FOOD	AMOUNT TO BE GIVEN

SUSTAINING CARBOHYDRATE FOOD	AMOUNT TO BE GIVEN

- If the student requires more than 2 consecutive fast acting carbohydrate treatments, as per their Diabetes Action Plan, call the student's parent/carer. Continue hypo treatment if needed while awaiting further advice.
- All hypo treatment foods should be provided by the parent/carer.
- Ideally, packaging should be in serve size bags or containers and labelled as **fast acting carbohydrate** food and **sustaining carbohydrate** food.

Mild hypoglycaemia is common.

If the student is having more than 3 episodes of low BGLs at school in a week, make sure that the parent/carer is aware.

SEVERE HYPOGLYCAEMIA (HYPO) MANAGEMENT

Severe hypoglycaemia is not common.

Follow the student's Diabetes Action Plan for any episode of severe hypoglycaemia.

DO NOT attempt to give anything by mouth to the student or rub anything onto the gums as this may lead to choking.

If the school is located more than **30 minutes** from a reliable ambulance service, then staff should discuss Glucagon injection training with the student's Diabetes Treating Team.

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NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

HIGH BLOOD GLUCOSE LEVELS

HIGH BLOOD GLUCOSE LEVELS (Hyperglycaemia / Hyper)

- Although not ideal, BGLs above target range are common.
- **If BGL is 15.0 mmol/L or more**, follow the student's Diabetes Action Plan.
- If the student is experiencing frequent episodes of high BGLs at school, make sure the parent/carer is aware.

KETONES

KETONES

- Ketones occur most commonly when there is not enough insulin in the body.
- Ketones are produced when the body breaks down fat for energy.
- Ketones can be dangerous in high levels.

You will be required to check the student's ketone level if

- Student is unwell **or**
- BGL is above 15.0 mmol/L

☐ Blood ketone check ☐ Urine ketone check

If ketones are **more than 1.0 mmol/L, or dark purple on urine strip**, follow action for ketones on the student's Diabetes Action Plan.

EATING AND DRINKING

EATING AND DRINKING

- Younger students will require supervision to ensure all food is eaten.
- The student should not exchange food/meals with another student.
- Seek parent/carer advice regarding appropriate foods for parties/celebrations that are occurring at school.
- Always allow access to drinking water and toilet (high glucose levels can cause increased thirst and extra toilet visits).

Does the student have coeliac disease? ☐ No ☐ Yes*

*Seek parent/carer advice regarding appropriate food and hypo treatments.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

PHYSICAL ACTIVITY

A blood glucose meter and hypo treatment should always be available.

- Check blood glucose level before physical activity.
- Physical activity **may lower** glucose levels.
- The student may require an extra serve of carbohydrate food before every 30 minutes of planned physical activity or swimming as provided in the Activity Food Box.

ACTIVITY FOOD BOX LOCATION: _____

ACTIVITY FOOD BOX

CARBOHYDRATE FOOD TO BE USED	AMOUNT TO BE GIVEN

- Physical activity should not be undertaken **if BGL less than 4.0 mmol/L**. Refer to the Diabetes Action Plan for hypo treatment.
- Vigorous activity **should not** be undertaken **if BGL is greater than or equal to 15.0 mmol/L and/or the student is unwell**.

EXCURSIONS / INCURSIONS

It is important to plan for extracurricular activities.

Consider the following:

- Ensure blood glucose meter, blood glucose strips, ketone strips, insulin, hypo and activity food are readily accessible.
- Plan for meal and snack breaks.
- Always have hypo treatment available.

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

CAMPS

CAMPS

It is important to plan for school camps and consider the following:

- Parents/carers need to be informed of any school camps at the **beginning of the year.**
- A separate and specific **Camp Diabetes Management Plan** is required.
- Parents/carers should request a **Camp Diabetes Management Plan** from their Diabetes Treating Team.
- The student's Diabetes Treating Team will prepare the **Camp Diabetes Management Plan** and require at least 4 weeks' notice to do so.
- Parents/carers will need a copy of the camp menu and activity schedule.
- At least 2 responsible staff attending the camp should have a general understanding of type 1 diabetes and the support that the student requires to manage their condition for the duration of the camp.
- If the camp location is more than **30 minutes** from a reliable ambulance service, **Glucagon injection training will be required.**
- School staff will need to discuss any training needs at least 4 weeks before the camp with the student's parents/carers or Diabetes Treating Team.

EXAMS

EXAMS

- BGL should be checked before an exam.
- BGL should be greater than 4.0 mmol/L before exam is started.
- Blood glucose meter, monitoring strips, hypo treatments and water should be available in the exam setting.
- Continuous Glucose Monitoring (CGM) or Flash Glucose Monitoring (FGM) devices and receivers (smart phones) should be available in the exam setting.
- Extra time will be required if a hypo occurs or for toilet privileges.

APPLICATIONS FOR SPECIAL CONSIDERATION

National Assessment Program Literacy and Numeracy (NAPLAN)
Applies to Grade 3, Grade 5, Year 7, Year 9. Check National Assessment Program website – Adjustment for student with disability for further information.

Victorian Certificate of Education (VCE)
Should be lodged at the beginning of Year 11 and 12. Check Victorian Curriculum and Assessment Authority (VCAA) requirements.

NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

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EXTRA SUPPLIES

Provided for diabetes care at the school by parent/carer

- ☐ Insulin and syringes / pens / pen needles
- ☐ Finger prick device
- ☐ Blood glucose meter
- ☐ Blood glucose strips
- ☐ Blood ketone strips
- ☐ Urine ketone strips
- ☐ Sharps container
- ☐ Hypo food
- ☐ Activity food

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

AGREEMENTS

PARENT/CARER

- ☐ I have read, understood and agree with this plan.
- ☐ I give consent to the school to communicate with the Diabetes Treating Team about my child's diabetes management at school.

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

SCHOOL REPRESENTATIVE

- ☐ I have read, understood and agree with this plan.

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

ROLE ☐ Principal ☐ Vice principal

☐ Other (please specify) _____

SIGNATURE _____ DATE _____

DIABETES TREATING MEDICAL TEAM

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

DIABETES ACTION PLAN 2020 SCHOOL SETTING

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

Insulin pump

LOW Hypoglycaemia (Hypo)

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

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

Note: Symptoms may not always be obvious

DO NOT LEAVE STUDENT ALONE
DO NOT DELAY TREATMENT

MILD

Student conscious
(Able to eat hypo food)

Step 1: Give fast acting carbohydrate
e.g. _____
_____

Step 2: Recheck BGL in 15 mins
If BGL **less than** 4.0 repeat **Step 1**
If BGL **greater than** or equal to 4.0, go to **Step 3**

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

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

SEVERE

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

First Aid DRSABCD
Stay with unconscious student

CALL AN AMBULANCE
DIAL 000

Contact parent/carer
when safe to do so

HIGH Hyperglycaemia (Hyper)

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

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

Note: Symptoms may not always be obvious

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

Blood ketones less than 0.6
- Enter BGL into pump
- Accept Correction bolus
- 1–2 glasses water per hour; extra toilet visits may be required
- Recheck BGL in 2 hours

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

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

Blood ketones greater than or equal to 0.6

POTENTIAL LINE FAILURE
- Will need injected insulin and line change
- This is the parent/ carer responsibility or student (if they have the required insulin pump skills)
- Contact parent/carer for further advice

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

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

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STUDENT'S NAME _____
_____
DATE OF BIRTH GRADE / YEAR
_____
NAME OF SCHOOL
_____
_____

INSULIN The insulin pump continually delivers insulin. The pump will deliver insulin based on carbohydrate food amount and BGL entries.
☐ Hybrid closed loop (read and respond to pump commands)
Pump button pushing:
☐ independently ☐ with supervision ☐ with assistance

THIS STUDENT IS WEARING
☐ Continuous Glucose Monitoring (CGM)
☐ Flash Glucose Monitoring (FGM)

ROUTINE BGL CHECKING TIMES
These are still required if student is using CGM/FGM
- Anytime, anywhere in the school
- Before main meal
- Anytime hypo is suspected
- Confirm sensor glucose hypo reading
- Before physical education / sport
- Before exams or tests

PHYSICAL EDUCATION / SPORT
- Check BGL before physical education/sport.
- 1 serve of sustaining carbohydrate food before every 30 mins of planned activity. **DO NOT BOLUS** for the carbohydrate food serve.
- Vigorous activity **should not** be undertaken if BGL is greater than or equal to 15.0 **and** blood ketones are greater than or equal to 0.6.

PARENT / CARER NAME _____
CONTACT NO. _____
DIABETES TREATING TEAM _____
CONTACT NO. _____
DATE PLAN CREATED _____

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

STUDENT'S NAME **GRADE / YEAR**

RESPONSIBLE STAFF

School staff who have voluntarily agreed to undertake training and provide support with diabetes care to the student.

STAFF MEMBER	GLUCOSE CHECKING	INSULIN PUMP

INSULIN PUMP

The student wears an insulin pump that continually delivers insulin.

Insulin pump model: _____

☐ Hybrid Closed Loop Pump – Refer to Appendix for further details.

Is supervision/assistance required for pump button pushing? ☐ Yes ☐ No

If yes, the responsible staff need to:

☐ Remind ☐ Observe ☐ Enter information and button push

A Medication Authority Form is required if school staff are required to administer / supervise insulin given via the pump.

STUDENT INSULIN PUMP SKILLS

Able to independently count carbohydrate foods ☐ Yes ☐ No (Parent/carer will label all food)

Able to enter blood glucose levels (BGL) and carbohydrate grams into pump

☐ Yes ☐ No (Adult assistance required)

Able to do a 'Correction Bolus' ☐ Yes ☐ No (Adult assistance required)

Able to disconnect & reconnect pump if needed ☐ Yes ☐ No (Adult assistance required)

Restart pump manually ☐ NA ☐ Yes ☐ No (Adult assistance required)

Able to prepare and insert a new infusion set if needed ☐ Yes ☐ No (Contact parent/carer)

Give an insulin injection if needed ☐ Yes ☐ No (Adult assistance required)

Able to troubleshoot pump alarms and malfunctions ☐ Yes ☐ No (Contact parent/carer)

BLOOD GLUCOSE LEVEL (BGL) CHECKING

Target range for blood glucose levels (BGLs): 4 – 7 mmol/L

- BGL results outside of this target range are common.
- BGL check should be done where the student is, whenever needed.
- **The student should always wash and dry their hands before doing the BGL check.**

Blood glucose levels will vary day-to-day and be dependent on a number of factors such as:

- Insulin Dose
- Growth spurts
- Illness / infection
- Excitement / stress
- Type/quantity of food
- Age
- Level of activity

Is the student able to do their own blood glucose check independently?

☐ Yes ☐ No

If NO, the responsible staff member needs to

☐ Do the check ☐ Assist ☐ Observe ☐ Remind

TIMES TO CHECK BGLS (tick all those that apply)

☐ Anytime, anywhere ☐ Before snack ☐ Before lunch
☐ Before activity ☐ Before exams/tests ☐ Beginning of after-school care session
☐ When feeling unwell ☐ Anytime hypo suspected
☐ Other routine times – please specify _____

_____

- Further action is required if BGL is **less than 4.0 mmol/L** or **greater than or equal to 15.0 mmo/L**. Refer to Diabetes Acton Plan.
- If the meter reads '**LO**' this means the BGL is too low to be measured by the meter — follow the hypoglycaemia (Hypo) treatment on Diabetes Action Plan.
- If the meter reads '**HI**' this means the BGL is too high to be measured by the meter — follow hyperglycaemia (Hyper) treatment on Diabetes Action Plan.

SENSOR GLUCOSE (SG) MONITORING

The student is wearing

☐ Continuous Glucose Monitor (CGM)
- ☐ Dexcom G4®
- ☐ Guardian™ Connect
- ☐ Dexcom G5®
- ☐ Guardian™ Sensor 3

☐ Flash Glucose Monitor (FGM)
- ☐ Freestyle Libre

continued...

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NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

- CGM and FGM consist of a small sensor that sits under the skin and measures glucose levels in the fluid surrounding the cells (interstitial fluid).
- These devices are not compulsory management tools unless the student is on a Hybrid Closed Loop pump.
- With CGM, a transmitter sends data to either a receiver, phone app or insulin pump.
- With FGM, the device will only give a glucose reading when the sensor disc is scanned with a reader or phone app.
- A sensor glucose (SG) reading can differ from a finger prick blood glucose reading during times of rapidly changing glucose levels e.g. eating, after insulin administration, during exercise.
- Therefore, **LOW** or **HIGH** SG readings **must** be confirmed by a finger prick blood glucose check.

Hypo treatment is based on a blood glucose finger prick result.

CGM ALARMS

- CGM alarms may be 'on' or 'off'.
- If 'on' the CGM will alarm if interstitial glucose is low or high.

ACTION: **Check finger prick blood glucose level (BGL) and follow Diabetes Action Plan for treatment.**

- FGM device does not have alarm settings.

LOW GLUCOSE SUSPEND

Certain insulin pumps may be programmed to **STOP** insulin delivery when the CGM glucose level is low or predicted to go low.

The student has low glucose suspend activated: ☐ Yes ☐ No

ACTION: **for any low alert a finger prick blood glucose check is required. If BGL less than 4.0 mmol/L, treat hypo as per Diabetes Action Plan.**

USE AT SCHOOL

- Staff are not expected to do more than the current routine diabetes care as per the student's Diabetes Action and Management plans.
- Staff do not need to put CGM apps on their computer, smart phone or carry receivers .
- Parents/carers are the primary contact for any questions regarding CGM/FGM use.
- Some CGM devices can be monitored remotely by family members. They should only contact the school if they foresee a prompt response is required.
- If the sensor/transmitter falls out, staff are required to keep it in a safe place to give to parents/carers.
- The sensor can remain on the student during water activities.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

LOW BLOOD GLUCOSE LEVELS (Hypoglycaemia / Hypo)

Follow the student's Diabetes Action Plan **if BGL less than 4.0 mmol/L**.
Mild hypoglycaemia can be treated by using supplies from the student's HYPO BOX.

HYPO BOX LOCATION/S: _____

HYPO BOX

FAST ACTING CARBOHYDRATE FOOD	AMOUNT TO BE GIVEN

SUSTAINING CARBOHYDRATE FOOD	AMOUNT TO BE GIVEN

- If the student requires more than 2 consecutive fast acting carbohydrate treatments, as per their Diabetes Action Plan, call the student's parent/carer. Continue hypo treatment if needed while awaiting further advice.
- **DO NOT** give an insulin bolus for this treatment.
- All hypo treatment foods should be provided by the parent/carer.
- Ideally, packaging should be in serve size bags or containers and labelled as **fast acting carbohydrate** food and **sustaining carbohydrate** food.

Mild hypoglycaemia is common.

If the student is having more than 3 episodes of low BGLs at school in a week, make sure that the parent/carer is aware.

SEVERE HYPOGLYCAEMIA (HYPO) MANAGEMENT

Severe hypoglycaemia is not common.

Follow the student's Diabetes Action Plan for any episode of severe hypoglycaemia.

DO NOT attempt to give anything by mouth to the student or rub anything onto the gums as this may lead to choking.

If the school is located more than **30 minutes** from a reliable ambulance service, then staff should discuss Glucagon injection training with the student's Diabetes Treating Team.

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NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

HIGH BLOOD GLUCOSE LEVELS

HIGH BLOOD GLUCOSE LEVELS (Hyperglycaemia / Hyper)

- Although not ideal, BGLs above target range are common.
- **If BGL is 15.0 mmol/L or more**, follow the student's Diabetes Action Plan.
- If the student is experiencing frequent episodes of high BGLs at school, make sure the parent/carer is aware.

KETONES

KETONES

- Ketones occur most commonly when there is not enough insulin in the body.
- Ketones are produced when the body breaks down fat for energy.
- Ketones can be dangerous in high levels.

Check blood ketone level if:

- Student is unwell **or**
- BGL is above 15.0 mmol/L

If ketones are **more than 0.6 mmol/L**, follow action for ketones on the student's Diabetes Action Plan.

EATING AND DRINKING

EATING AND DRINKING

- The student will need to have an insulin bolus from the insulin pump before carbohydrate foods are eaten.
- The insulin dose will be determined by the pump based on the grams of carbohydrate food they will be eating and the current blood glucose level.
- For younger students, all carbohydrate food should be clearly labelled by the parent/carer with carbohydrate amount in grams. It is not the responsibility of school staff to count carbohydrates, although they may need to assist the student to add up the food amounts that they wish to eat.
- Younger students will require supervision to ensure all food is eaten.
- The student should not exchange food/meals with another student.
- Seek parent/carer advice regarding appropriate foods for parties/celebrations that are occurring at school.
- Always allow access to drinking water and toilet (high glucose levels can cause increased thirst and extra toilet visits).

Does the student have coeliac disease? ☐ No ☐ Yes*

*Seek parent/carer advice regarding appropriate food and hypo treatments.

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

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

PHYSICAL ACTIVITY

A blood glucose meter and hypo treatment should always be available.

- Check blood glucose level before physical activity.
- Physical activity **may lower** glucose levels.
- The student may require an extra serve of carbohydrate food before every 30 minutes of planned physical activity or swimming as provided in the Activity Food Box.

ACTIVITY FOOD BOX LOCATION: _____

ACTIVITY FOOD BOX

CARBOHYDRATE FOOD TO BE USED	AMOUNT TO BE GIVEN

- Physical activity should not be undertaken **if BGL less than 4.0 mmol/L**. Refer to the Diabetes Action Plan for hypo treatment.
- Vigorous activity should **not** be undertaken if **BGL is greater than or equal to 15.0 mmol/L and blood ketones are greater than or equal to 0.6 mmol/L**.
- **Do not enter the BGL into the pump within 1 hour of completing activity**; if lunch occurs immediately after physical activity, only enter the amount of carbohydrate food to be eaten.
- Disconnect the pump for vigorous activity/swimming.* The student can be disconnected from the pump for up to 90 minutes.
  *Extra details for Hybrid Closed Loop Insulin Pump in Appendix.

EXCURSIONS / INCURSIONS

It is important to plan for extracurricular activities.

Consider the following:

- Ensure blood glucose meter, blood glucose strips, blood ketone strips, hypo and activity food are readily accessible.
- Plan for meal and snack breaks.
- Always have hypo treatment available.

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

CAMPS

CAMPS

It is important to plan for school camps and consider the following:

- Parents/carers need to be informed of any school camps at the **beginning of the year.**
- A separate and specific **Camp Diabetes Management Plan** is required.
- Parents/carers should request a **Camp Diabetes Management Plan** from their Diabetes Treating Team.
- The student's Diabetes Treating Team will prepare the **Camp Diabetes Management Plan** and require at least 4 weeks' notice to do so.
- Parents/carers will need a copy of the camp menu and activity schedule.
- At least 2 responsible staff attending the camp should have a general understanding of type 1 diabetes and the support that the student requires to manage their condition for the duration of the camp.
- If the camp location is more than **30 minutes** from a reliable ambulance service, **Glucagon injection training will be required.**
- School staff will need to discuss any training needs at least 4 weeks before the camp with the student's parents/carers or Diabetes Treating Team.

EXAMS

EXAMS

- BGL should be checked before an exam.
- BGL should be greater than 4.0 mmol/L before exam is started.
- Blood glucose meter, monitoring strips, hypo treatments and water should be available in the exam setting.
- Continuous Glucose Monitoring (CGM) or Flash Glucose Monitoring (FGM) devices and receivers (smart phones) should be available in the exam setting.
- Extra time will be required if a hypo occurs or for toilet privileges.

APPLICATIONS FOR SPECIAL CONSIDERATION

National Assessment Program Literacy and Numeracy (NAPLAN)
Applies to Grade 3, Grade 5, Year 7, Year 9. Check National Assessment Program website – Adjustment for student with disability for further information.

Victorian Certificate of Education (VCE)
Should be lodged at the beginning of Year 11 and 12. Check Victorian Curriculum and Assessment Authority (VCAA) requirements.

NAME _____
DATE OF BIRTH _____
DATE PLAN CREATED _____

EXTRA SUPPLIES

Provided for diabetes care at the school by parent/carer

- ☐ Finger prick device
- ☐ Blood glucose meter
- ☐ Blood glucose strips
- ☐ Blood ketone strips
- ☐ Sharps container
- ☐ Hypo food
- ☐ Activity food

☐ Infusion sets and lines	☐ Student use	☐ Parent/carer use
☐ Reservoirs	☐ Student use	☐ Parent/carer use
☐ Cartridges	☐ Student use	☐ Parent/carer use
☐ Inserter (if applicable)	☐ Student use	☐ Parent/carer use
☐ Insulin pen and pen needles	☐ Student use	☐ Parent/carer use

- ☐ Batteries (for insulin pump)
- ☐ Charging cable (for insulin pump)

GLOSSARY OF TERMS
COMMON INSULIN PUMP TERMINOLOGY

Insulin pump also known as continuous subcutaneous insulin infusion (CSII)
Small batter operated, computerised device for delivering insulin.

Cannula
A tiny plastic or steel tube inserted under the skin to deliver insulin. Held in place by an adhesive pad.

Line or Tubing
The plastic tubing connecting the pump reservoir/cartridge to the cannula.

Reservoir/Cartridge
Container which holds the insulin within the pump.

Basal
Background insulin delivered continuously.

Bolus
Insulin for food delivered following entry of BGL and carbohydrate food amount to be eaten.

Correction bolus
Extra insulin dose given to correct an above target BGL and/or to clear ketones.

Line failure
Disruption of insulin delivery due usually to line kinking or blockage.

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NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

AGREEMENTS

PARENT/CARER

- ☐ I have read, understood and agree with this plan.
- ☐ I give consent to the school to communicate with the Diabetes Treating Team about my child's diabetes management at school.

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

SCHOOL REPRESENTATIVE

- ☐ I have read, understood and agree with this plan.

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

ROLE ☐ Principal ☐ Vice principal

☐ Other (please specify) _____

SIGNATURE _____ DATE _____

DIABETES TREATING MEDICAL TEAM

NAME

FIRST NAME (PLEASE PRINT) _____ FAMILY NAME (PLEASE PRINT) _____

SIGNATURE _____ DATE _____

NAME _____

DATE OF BIRTH _____

DATE PLAN CREATED _____

For the latest updates, please refer to this policy which is saved on the server.

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

For the latest updates, please refer to this policy which is saved on the server.

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

For the latest updates, please refer to this policy which is saved on the server.

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					

For the latest updates, please refer to this policy which is saved on the server.

Epilepsy: Know me, Support me.

Insert jpeg image here

Epilepsy Management Plan

Name of person living with epilepsy:		
Date of birth:	Date plan written:	Date to review:

1. General information

Medication records located:
Seizure records located:
General support needs document located:
Epilepsy diagnosis (if known):

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

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

These documents are located:

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

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

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

5. My seizure description and seizure support needs:

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

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

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

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

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

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

7. My specific post-seizure support:

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

8. My risk/safety alerts:

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

Risk	What will reduce this risk for me?

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

If 'yes' describe:

This plan has been co-ordinated by:

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

Endorsement by treating doctor:

Your doctor's name:
Telephone:

Doctor's signature:	Insert jpeg here	Date:

For the latest updates, please refer to this policy which is saved on the server.

Attach this document to your Epilepsy Management Plan if Rectal Valium is prescribed. This Emergency Plan should be completed by the prescribing doctor in consultation with the person and/or their family or carer. It must be attached to their epilepsy management plan which has been signed by their doctor. The Epilepsy Foundation recommends this plan be reviewed and signed by the person's doctor annually.

epilepsy foundation

Emergency Medication Management Plan
Rectal Valium (only to be administered by a trained person)

Rectal Valium Management Plan for (name):

Date: | Date of birth:

Administration method:
Rectal ☒

1. FIRST DOSE Rectal Valium

First dose = mg

For single seizures:

☐ As soon as a *(seizure type)* begins

☐ If the *(seizure type)* continues longer than mins

For clusters of seizures:

☐ When *(number)* *(seizure type)* occur/s within mins hrs

☐ Other *(please specify)*:

Special instructions:

2. SECOND DOSE Rectal Valium

Second dose = mg

☐ Not prescribed OR

☐ If the *(seizure type)* continues for another mins following the first dose

☐ When another *(number)* *(seizure type)* occur/s within mins hrs following the first dose

☐ Other *(please specify)*:

Special instructions:

3. Maximum number of Rectal Valium doses to be given in a 24-hour period

Maximum number:

4. Dial 000 to call the ambulance:

☐ Prior to administering Rectal Valium

☐ If the seizure has not stopped minutes after giving the Rectal Valium

☐ Other *(please specify)*:

5. Describe what to do after Rectal Valium has been administered:

6. Prescribing doctor or specialist

Name of doctor:	
Telephone:	Date:

Signature

Insert jpeg here

7. Family/carers to complete

Any special instructions e.g. storage of medication, when on outings etc. or people to contact if emergency medication is given.

Name:	Relationship:
Telephone:	Date:
Email:	

Signature

Insert jpeg here

Recommended RECTAL VALIUM storage information:

- **Keep out of reach of children**
- **Protect from light and store at room temperature (below 25° C)**
- **Regularly check the expiry date.**

APPENDIX 19: ASTHMA CARE PLAN FOR EDUCATION AND CARE SERVICES

(This form must be completed together with an Asthma Action Plan)

For the latest updates, please refer to this policy which is saved on the server.

ASTHMA CARE PLAN FOR EDUCATION AND CARE SERVICES

PHOTO OF STUDENT (OPTIONAL)

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

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

Plan date ___/___/20__

Review date ___/___/20__

PLEASE PRINT CLEARLY

Student's name: _____ **Date of Birth** _____

Address: _____

Phone: _____

Medicare No: _____ **Health Insurance Provider** _____

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

ASTHMA AUSTRALIA

MANAGING AN ASTHMA ATTACK

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

DAILY ASTHMA MANAGEMENT

This student's usual asthma signs:

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

Frequency and severity:

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

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

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

MEDICATION PLAN

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

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

DOCTOR

Name of doctor _____

Address _____

Phone _____

Signature _____ Date _____

PARENT/GUARDIAN

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

Signature _____ Date _____

Name _____

EMERGENCY CONTACT INFORMATION

Contact name _____

Phone _____

Mobile _____

Email _____

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

HOLY EUCAHRIST SCHOOL
1a Oleander Drive St Albans VIC 3021

Date of approval: June 2018 | Approved by: CEO Asthma Australia | Date of review: June 2018 | AACPED2018 Care Plan for Schools A4 | 6 June 2018

For the latest updates, please refer to this policy which is saved on the server.

ASTHMA FIRST AID

1 SIT THE PERSON UPRIGHT

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

2 GIVE 4 SEPARATE PUFFS OF BLUE/GREY RELIEVER PUFFER

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

– **Repeat** until **4 puffs** have been taken
– **Remember: Shake, 1 puff, 4 breaths**

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

3 WAIT 4 MINUTES

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

OR give 1 more dose of Bricanyl or Symbicort inhaler

IF THERE IS STILL NO IMPROVEMENT

4 DIAL TRIPLE ZERO (000)

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

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

Translating and Interpreting Service
131 450

ASTHMA AUSTRALIA

Contact Asthma Australia

1800 ASTHMA
(1800 278 462)

asthma.org.au

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

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

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

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 20: ASTHMA ACTION PLAN – FOR USE WITH A PUFFER *(Plan prepared by Doctor or Nurse practitioner)*

FOR USE WITH A PUFFER

ASTHMA ACTION PLAN

VICTORIAN SCHOOLS

Student's name: _____

DOB: _____

Confirmed triggers: _____

PHOTO

ASTHMA AUSTRALIA

☐ 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: _____

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 the 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.

SIGNS AND SYMPTOMS	MILD TO MODERATE	SEVERE	LIFE-THREATENING
	• Minor difficulty breathing • May have a cough • May have a wheeze • Other signs to look for:	• 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)	• 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)

Emergency contact name: _____

Work ph: _____

Home ph: _____

Mobile ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Date prepared: _____

Date of next review: _____

- 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.

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 21:

ASTHMA ACTION PLAN – FOR USE WITH A PUFFER AND SPACER *(Plan prepared by Doctor or Nurse practitioner)*

FOR USE WITH PUFFER AND SPACER

ASTHMA ACTION PLAN

VICTORIAN SCHOOLS

Student's name: _____

DOB: _____

Confirmed triggers: _____

_____

_____

PHOTO

ASTHMA AUSTRALIA

- ☐ 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: _____

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 the puffer before each puff
   Puff 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, repreat 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.

SIGNS AND SYMPTOMS	MILD TO MODERATE	SEVERE	LIFE-THREATENING
	• Minor difficulty breathing • May have a cough • May have a wheeze • Other signs to look for:	• 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)	• 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)

Emergency contact name: _____

Work ph: _____

Home ph: _____

Mobile ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Date prepared: _____

Date of next review: _____

- 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).

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 22:

ASTHMA ACTION PLAN – FOR USE WITH A BRICANYL TURBUHALER *(Plan prepared by Doctor or Nurse practitioner)*

FOR USE WITH A BRICANYL TURBUHALER

ASTHMA ACTION PLAN

VICTORIAN SCHOOLS

Student's name: _____

DOB: _____

Confirmed triggers: _____

_____

_____

PHOTO

ASTHMA AUSTRALIA

☐ 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: _____

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(s) 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.

SIGNS AND SYMPTOMS	MILD TO MODERATE	SEVERE	LIFE-THREATENING
	• Minor difficulty breathing • May have a cough • May have a wheeze • Other signs to look for:	• 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)	• 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)

Emergency contact name: _____

Work ph: _____

Home ph: _____

Mobile ph: _____

Plan prepared by Dr or Nurse Practitioner: _____

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

Date prepared: _____

Date of next review: _____

- 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 breath for about 5 seconds or as long as comfortable. Breathe out.

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 23: SCHOOL CAMP AND EXCURSION – ASTHMA UPDATE FORM

(This form is to be attached to all excursion and camp permission notes** and **must be completed by parents/caregivers prior)

SCHOOL CAMP AND EXCURSION

VICTORIAN SCHOOLS

ASTHMA UPDATE FORM

Student's name:

DOB:

Confirmed triggers:

Has the student been hospitalised due to asthma, had an acute asthma attack or worsening asthma in the last two weeks? ☐ Y ☐ N

Has the student's asthma medications changed in the last two weeks? ☐ Y ☐ N

Is the student well enough to attend camp/excursion? ☐ Y ☐ N

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? ☐ Y ☐ N
If YES, please provide details:

Nature of illness? _____ When? _____

Severity? _____ Has this affected their asthma? ☐ Y ☐ N

ALLERGIC RHINITIS (HAY FEVER)

Does the student hay fever? ☐ Y ☐ N Does the student have an action plan for hay fever? ☐ Y ☐ N

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

Doctor's Name:

Phone:

Address:

Emergency Contact:

Phone:

The information provided on this plan is true and correct.

Signed:

Date:

Additional information

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

ASTHMA AUSTRALIA

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www.allergy.org.au

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.

ASCIA INFORMATION FOR PATIENTS, CONSUMERS AND CARERS

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/

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

Website: www.allergy.org.au
Email: info@allergy.org.au
Postal address: PO Box 450 Balgowlah NSW 2093 Australia

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 25: INDIVIDUAL ANAPHYLAXIS MANAGEMENT PLAN – To be completed together with the Anaphylaxis Action Plan

For the latest updates, please refer to this policy which is saved on the server.

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®)		

For the latest updates, please refer to this policy which is saved on the server.

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:

APPENDIX 26: ACTION PLAN FOR ANAPHYLAXIS – For EpiPen Adrenaline Autoinjectors *(Plan prepared by Doctor or Nurse*

For the latest updates, please refer to this policy which is saved on the server.

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ACTION PLAN FOR Anaphylaxis

For use with 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 doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises:

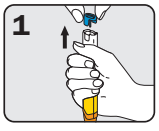
- **Medications specified on this plan to be administered according to the plan.**
- **Prescription of 2 adrenaline autoinjectors.**
- **Review of this plan is due by the date below.**

Date: _____

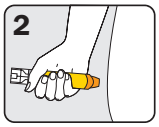
Signed: _____

Date: _____

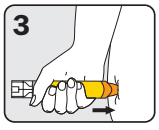
How to give EpiPen® adrenaline (epinephrine) autoinjectors



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



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



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

REMOVE EpiPen®

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

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

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

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

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

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

ACTION FOR ANAPHYLAXIS

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

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

2 Give adrenaline autoinjector

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

4 Phone family/emergency contact

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

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

If in doubt give adrenaline autoinjector

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

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

Asthma reliever medication prescribed: ☐ Y ☐ N

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

For the latest updates, please refer to this policy which is saved on the server.

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:	

APPENDIX 27: ACTION PLAN FOR ANAPHYLAXIS – For Generic Adrenaline Autoinjectors *(Plan prepared by Doctor or Nurse)*

For the latest updates, please refer to this policy which is saved on the server.

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www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Photo

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by doctor or nurse practitioner (np):

_____

The treating doctor or np hereby authorises:

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

  Date: _____

Signed: _____

Date: _____

Refer to the device label for instructions on how to give an adrenaline (epinephrine) autoinjector.

Instructions are also on the ASCIA website www.allergy.org.au/anaphylaxis

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 7.5-20kg.

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

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

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

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

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

ACTION FOR ANAPHYLAXIS

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

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

2 Give adrenaline autoinjector

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

4 Phone family/emergency contact

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

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

If in doubt give adrenaline autoinjector

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

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

Asthma reliever medication prescribed: ☐ Y ☐ N

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

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:	

For the latest updates, please refer to this policy which is saved on the server.

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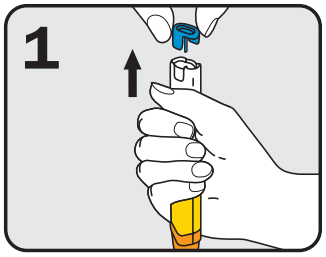
australasian society of clinical immunology and allergy
www.allergy.org.au

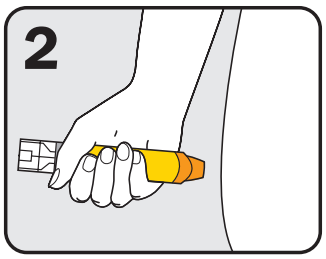
FIRST AID PLAN FOR Anaphylaxis

For use with EpiPen® adrenaline (epinephrine) autoinjectors

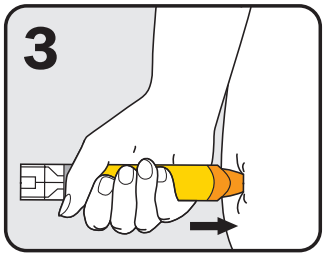
How to give EpiPen® adrenaline (epinephrine) autoinjectors



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



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



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

REMOVE EpiPen®

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

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

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

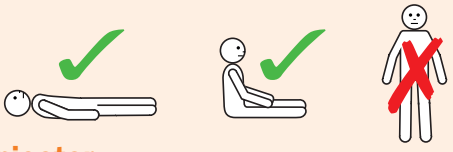
Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

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

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

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk
- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**



2 Give adrenaline autoinjector

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

4 Phone family/emergency contact

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

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

If in doubt give adrenaline autoinjector

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

ALWAYS give adrenaline autoinjector FIRST, if someone has SEVERE AND SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice), even if there are no skin symptoms. THEN SEEK MEDICAL HELP.

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

For the latest updates, please refer to this policy which is saved on the server.

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

FIRST AID PLAN FOR Anaphylaxis

For use with adrenaline (epinephrine) autoinjectors - refer to the device label for instructions

Translated versions of this document are on the ASCIA website www.allergy.org.au/anaphylaxis#ta5

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

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

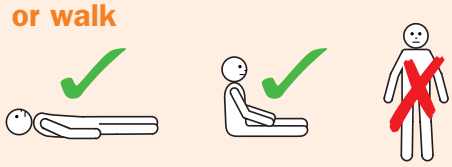
Mild to moderate allergic reactions (such as hives or swelling) may not always occur before anaphylaxis

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

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

ACTION FOR ANAPHYLAXIS

1 Lay person flat - do NOT allow them to stand or walk
- **If unconscious, place in recovery position**
- **If breathing is difficult allow them to sit**



2 Give adrenaline autoinjector

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

4 Phone family/emergency contact

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

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

If in doubt give adrenaline autoinjector

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

ALWAYS give adrenaline autoinjector FIRST, if someone has SEVERE AND SUDDEN BREATHING DIFFICULTY (including wheeze, persistent cough or hoarse voice), even if there are no skin symptoms. THEN SEEK MEDICAL HELP.

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

Adrenaline autoinjectors (300 mcg) are prescribed for children over 20kg and adults. Adrenaline autoinjectors (150 mcg) are prescribed for children 7.5-20kg.

Fast Facts

Anaphylaxis

1 Anaphylaxis is a potentially life threatening, severe allergic reaction, that should always be treated as a medical emergency. It occurs after exposure to an allergen (usually to foods, insects or medicines), to which a person is allergic. Not all people with allergies are at risk of anaphylaxis.

2 Anaphylaxis symptoms include one or more of the following:

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or persistent cough
- Persistent dizziness and/or collapse
- Pale and floppy (in young children)
- Stomach (abdominal) pain, vomiting (insect allergy)

3 In some cases, anaphylaxis is preceded by a mild to moderate allergic reaction, with symptoms such as swelling of face, lips and/or eyes, hives or welts and stomach (abdominal) pain and vomiting.

4 Anaphylaxis requires immediate treatment with adrenaline (epinephrine), injected into the outer mid-thigh. It works rapidly to reverse the effects of anaphylaxis.

5 Adrenaline autoinjectors contain a single, fixed dose of adrenaline, and have been designed to be given by non-medical people, including the patient themselves (if they are well enough).

6 ASCIA Action Plans for Anaphylaxis include infographics to illustrate the first steps of action for anaphylaxis:

1 Lay person flat - DO NOT allow them to stand or walk
If unconscious, place in recovery position.
If breathing is difficult allow them to sit

2 Give adrenaline autoinjector
3 Phone ambulance - 000 (AU) or 111 (NZ)
4 Phone family/emergency contact
5 Further adrenaline doses may be given if no response after 5 minutes
6 Transfer person to hospital for at least 4 hours of observation

If in doubt give adrenaline autoinjector. Commence CPR at any time if person is unresponsive and not breathing normally.

More information: www.allergy.org.au/anaphylaxis

Other Fast Facts: www.allergy.org.au/patients/fast-facts

For the latest updates, please refer to this policy which is saved on the server.

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

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 32: MINSTER FOR EDUCATION – MINISTERIAL ORDER 706

Minister for Education

2 Treasury Place
East Melbourne, Victoria 3002
Telephone: +61 3 9637 3196
Facsimile: +61 3 9637 2680

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

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

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.

ASCIA INFORMATION FOR PATIENTS, CONSUMERS AND CARERS

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

For the latest updates, please refer to this policy which is saved on the server.

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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 Action 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, which can be lifesaving. This treatment should be give according to the attached ASCIA Action Plan for Anaphylaxis.

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, due to the reasons listed below.

Adrenaline autoinjector devices:

- need to be readily 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.

APPENDIX 35: ANNUAL RISK MANAGEMENT CHECKLIST

Holy Eucharist Catholic Primary School

1A Oleander Drive St Albans South
PH 8312 0900

Annual Risk Management Checklist

(To be completed at the start of each year - Revised 2020)

School 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 anaphylaxis 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. b. Are your school staff being assessed for their competency in using adrenaline autoinjectors (EpiPen®) within 30 days 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 for Anaphylaxis kept at the school (provided by the parent)?	☐ Yes ☐ No

a. Where are the Action Plans kept?	
15. Does the ASCIA Action Plan for Anaphylaxis 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) and out of direct sunlight?	☐ 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 Plan for Anaphylaxis) 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 which have expired?	☐ Yes ☐ No
27. Has the school signed up to EpiClub (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: Risk Minimisation 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 classroom?	☐ Yes ☐ No
b. In the schoolyard?	☐ 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 takes to get an individual's 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 classroom?	☐ 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 practice 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 will 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?	

For the latest updates, please refer to this policy which is saved on the server.

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www.allergy.org.au

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**.

The most common triggers of anaphylaxis (severe allergic reaction) are foods, insect stings and drugs (medications).

Signs and symptoms of allergic reactions

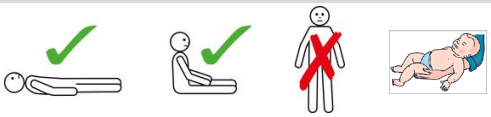
Mild or moderate reactions

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

Anaphylaxis – Indicated by <u>any one</u> of the following signs:

- Difficult/noisy breathing
- Swelling of tongue
- Swelling/tightness in throat
- Difficulty talking and/or hoarse voice
- Wheeze or sudden persistent cough*
- Persistent dizziness or collapse
- Pale and floppy (young children)
- Abdominal pain, vomiting (for insect sting or injected drug (medication) allergy).

Immediate actions



1. **Remove allergen** (if still present).
2. **Call for assistance**.
3. **Lay patient flat. Do not allow them to stand or walk. Do not hold infants upright.**
   If breathing is difficult, allow the patient to sit.
4. **Give INTRAMUSCULAR INJECTION (IMI) ADRENALINE (epinephrine) into outer mid thigh** without delay using an adrenaline autoinjector if available OR adrenaline ampoule and syringe.
5. **Give oxygen** (if available).
6. **Call ambulance** to transport patient if not already in a hospital setting.

ALWAYS give adrenaline 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.

*Unlike the cough in asthma, the onset of coughing during anaphylaxis is usually sudden.

- If required at any time, commence cardiopulmonary resuscitation (CPR).

To access ASCIA Action Plans and other anaphylaxis resources go to www.allergy.org.au/anaphylaxis

Adrenaline administration and dosages

Adrenaline (epinephrine) is the first line treatment of anaphylaxis and acts to reduce airway mucosal oedema, induce brochodilation, induce vasoconstriction and increase strength of cardiac contraction.

Give INTRAMUSCULAR INJECTION (IMI) OF ADRENALINE (1:1000) into outer mid thigh (0.01mg per kg up to 0.5mg per dose) without delay using an adrenaline autoinjector if available OR adrenaline ampoule and syringe, as follows.

Adrenaline (epinephrine) dosages chart			
Age (years)	**Weight (kg)**	**Vol. adrenaline 1:1000**	**Adrenaline autoinjector**
~<1	<7.5kg	0.1 mL	Not available
~1-2	10	0.1 mL	7.5*-20 kg (~<5yrs) 0.15mg device (e.g. EpiPen Jr)
~2-3	15	0.15 mL	
~4-6	20	0.2 mL	
~7-10	30	0.3 mL	>20kg (~>5yrs) 0.3mg device (e.g. EpiPen)
~10-12	40	0.4 mL	
~>12 and adults	>50	0.5 mL	

* Whilst 10-20kg was the previous weight guide for a 0.15mg adrenaline autoinjector device, a 0.15mg device may now also be prescribed for an infant weighting 7.5-10kg by health professionals who have made a considered assessment. Use of a 0.15mg device for treatment of infants weighing 7.5kg or more poses less risk, particularly when used without medical training, than use of an adrenaline ampoule and syringe.

Infants with anaphylaxis may retain pallor despite 2-3 doses of adrenaline, and this can resolve without further doses. More than 2-3 doses of adrenaline in infants may cause hypertension and tachycardia.

Pregnant women experiencing anaphylaxis need to be treated without delay and there are no absolute contraindications to adrenaline use in anaphylaxis. If clinical judgement deems that there is a risk of maternal death or foetal compromise due to inadequately treated anaphylaxis, then in pregnant women weighing > 50kg, consider giving 500 mcg IM adrenaline.

Note:

- If multiple doses are required for severe reactions (e.g. 2-3 doses administered at 5 minutes intervals), consider adrenaline infusion if skills and equipment are available.
- For emergency treatment of anaphylaxis, ampoules of adrenaline 1:1000 should be used for both IM doses and infusion if required (adrenaline 1:10 000 should not be used).

Positioning of patients

- Laying the patient flat will improve venous blood return to the heart.
- By contrast, placing the patient in an upright position, including holding infants upright over a shoulder, 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 minutes 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 that even sitting 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 after 2-3 adrenaline doses, or deterioration of patient, start IV adrenaline infusion, given by staff trained in its use or in liaison with an emergency/critical care specialist. 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 without specialised training as they may increase the risk of cardiac arrhythmia.

See Appendix for additional information.

Additional measures to consider if IV adrenaline infusion is ineffective

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 • In adults, selective vasoconstrictors only after advice from an emergency medicine/critical care specialist. See Appendix for dosage and 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.

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.

True biphasic reactions are 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.
https://allergy.org.au/hp/anaphylaxis/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, particularly 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)
- At least 3 litres of normal saline
- A hands-free phone in resuscitation room, to allow health care providers in remote locations to receive instructions by phone whilst keeping hands free for resuscitation.

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.

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 are 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.

Note: If a patient is nauseous, shaky, vomiting, or tachycardic but has a normal or elevated SBP, this may be adrenaline toxicity (side effects) 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 IV fluid infusion, resulting in the same initial rate of adrenaline 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. Infusions can be given with or without using an infusion pump.

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).
- 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.

Note:

- This protocol is intended for temporary use, when no infusion pump is available.
- Most anaphylactic reactions settle with only 1 mg adrenaline in 1 litre.
- Indefinite continuation of low concentration infusion increases risk of fluid overload.
- **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/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** (~0.1 microgram/kg/minute).
  - 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. Consider extracorporeal membrane oxygenation (ECMO) if resource is available.

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 37: ANAPHYLAXIS GUIDELINES – SAVED ON THE SERVER

VICTORIA State Government | Education and Training

Anaphylaxis Guidelines

A resource for managing severe allergies in Victorian schools

Issued: July 2017

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

*****ALTERNATIVELY YOU CAN VISIT THE 'VICTORIAN STATE GOVERNMENT - EDUCATION AND TRAINING' WEBSITE AT:**
https://www.education.vic.gov.au/school/teachers/health/Pages/anaphylaxisschl.aspx

For the latest updates, please refer to this policy which is saved on the server.

APPENDIX 38: ASTHMA GUIDELINES – SAVED ON THE SERVER

National Asthma Council Australia

AUSTRALIAN ASTHMA HANDBOOK

*****PLEASE FIND ASTHMA GUIDELINES (68 PAGES) SAVED ON THE SCHOOL SERVER**

*****ALTERNATIVELY YOU CAN VISIT THE 'NATIONAL ASTHMA COUNCIL' WEBSITE AT:**

https://www.asthmahandbook.org.au/download-print-complete-handbook

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DIAGNOSIS

Children

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