Individual Anaphylaxis Management Plan

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| This plan is to be completed by a Coastal Care authorised staff member on the basis of information from the client's medical practitioner (**ASCIA Action Plan for Anaphylaxis**).  The client’s ASCIA Action Plan for Anaphylaxis containing the emergency procedures plan (signed by the client's medical practitioner) and an up-to-date photo of the client - to be appended to this plan; and to inform Coastal Care if their medical condition changes. | | | | | | | |
| **Client name** | |  | | **Phone** | |  | |
| **Residential address** | |  | | | | | |
| **DOB** | |  | | **Email** | |  | |
| **Severely allergic to:** | |  | | | | | |
| **Other health conditions** | |  | | | | | |
| **Medication** | |  | | | | | |
| EMERGENCY CONTACT DETAILS | | | | | | | |
| **Name** | |  | | **Name** | |  | |
| **Relationship** | |  | | **Relationship** | |  | |
| **Home phone** | |  | | **Home phone** | |  | |
| **Work phone** | |  | | **Work phone** | |  | |
| **Mobile** | |  | | **Mobile** | |  | |
| **Address** | |  | | **Address** | |  | |
| **Medical practitioner contact** | | **Name** |  | | | | |
| **Phone** |  | | | | |
| **Emergency care to be provided** | |  | | | | | |
| **Storage location for adrenaline autoinjector (device specific)** | |  | | | | | |
| ENVIRONMENT | | | | | | | |
| To be completed by a Coastal Care authorised staff member. Please consider each environment/area (on and off site) e.g. excursions, etc. | | | | | | | |
| **Name of environment/area:** | | | | | | | |
| **Risk identified** | **Actions required to minimise the risk** | | | | **Who is responsible?** | | **Completion date?** |
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| **Name of environment/area:** | | | | | | | |
| **Risk identified** | **Actions required to minimise the risk** | | | | **Who is responsible?** | | **Completion date?** |
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| **Name of environment/area:** | | | | | | | |
| **Risk identified** | **Actions required to minimise the risk** | | | | **Who is responsible?** | | **Completion date?** |
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| **Name of environment/area:** | | | | | | | |
| **Risk identified** | **Actions required to minimise the risk** | | | | **Who is responsible?** | | **Completion date?** |
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| This Individual Anaphylaxis Management Plan will be reviewed on any of the following occurrences (whichever happen earlier):   * Annually. * If the client's medical condition, insofar as it relates to allergy and the potential for anaphylactic reaction, changes. * As soon as practicable after the client has an anaphylactic reaction.   when the client is to participate in an off-site activity, such as excursions, or at special events conducted, organised or attended by Coastal Care.  I have been consulted in the development of this Individual Anaphylaxis Management Plan.  I consent to the risk minimisation strategies proposed. | |
| Signature of client: |  |
| Date: |  |
| I have consulted the client and the relevant Coastal Care staff who will be involved in the implementation of this Individual Anaphylaxis Management Plan. | |
| Signature of Coastal care staff: |  |
| Date: |  |