

ATTACHMENT 5



Shine Bright EYM Allergy/Intolerance Management Plan

Child's Name:

Child's Photo

Child's Date of Birth:

Parent/Guardian 1

Name:

Home Ph:

Work Ph:

Mobile:

Parent/Guardian 2

Name:

Home Ph:

Work Ph:

Mobile:

Child's Doctor

Name:

Address of Clinic:

Other Emergency Contact

Name:

Home Ph:

Work Ph:

Mobile:

Phone:

Doctor Signed:

Date:

(Doctor to sign if prescription medication in plan)

Allergy Details:

What is your child allergic/intolerant to? Please list and give as much detail as possible, circumstances, types of exposure, forms of the allergen etc.

Has this allergy/intolerance been diagnosed by a doctor? Yes: No:

Signed Parent:

Shine Bright EYM Allergy/Intolerance Management Plan - continued

What are your child's symptoms in the event of an allergic reaction? Please give as much detail as possible, with progression and time frames.

What precautions can staff take to minimise the risk to this child?

What action do you want kindergarten staff to take in the case of an apparent allergic reaction or exposure to an allergen? List steps to take and any medications with doses and expiry date of medications.

1.

2.

3.

4.

5.

I agree to notify the centre staff if my child is suffering from the effects of an allergic reaction or is at more than usual risk. I give permission for the staff to follow the above steps in the case of apparent appearance of allergic symptoms. I understand that staff will contact myself and/or the other contacts above and/ or an ambulance if my child appears to be suffering from an allergic reaction. I give consent for this management plan to be displayed at the centre.

Parent/Guardian
Name:

Signed:

Date: