



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/carer

School: FAIRFIELD PRIMARY SCHOOL		
Phone: 9489 2966		
Student's name:		
Date of birth:	Year level:	
Severely allergic to:		
Other health conditions:		
Medication at school:		
Parent/carer contact:	Parent/carer information (1)	Parent/carer information (2)
	Name:	Name:
	Relationship:	Relationship:
	Home phone:	Home phone:
	Work phone:	Work phone:
	Mobile:	Mobile:
	Address:	Address:
Other emergency contacts (if parent/carer not available):		
Medical practitioner contact:		
Emergency care to be provided at school:		
EpiPen® storage:		
The following Anaphylaxis Management Plan has been developed with my knowledge and input and will be reviewed on		
Signature of parent:		Date:
Signature of principal (or nominee):		Date:

