Individual Health Plan & Emergency Health Plan

Student Name: _____ Gender: MALE / FEMALE
Date of Birth: _____ Year: _____

PALM BEACH CURRUMBIN STATE HIGH

Section A – Health Care Planning – to be completed by the parent/guardian

Name of your child's health condition or need:

_____

_____

Daily Management Planning (if required):

_____

_____

_____

_____

_____

_____

Section B – Emergency Health Plan – to be completed by parent/guardian and medical practitioner

_____

_____

_____

_____

_____

_____

Section C – Staff Training Requirements

Is specific training for staff required to manage your child's conditions? (You many like to discuss with a medical practitioner)

A. For daily management? ☐ YES ☐ NO If yes, please describe:

_____

_____

B. In an emergency? ☐ YES ☐ NO If yes, please describe:

_____

_____

Section D – Medication Instructions (Medication must be provided by parent/guardian)

	Medication 1	Medication 2	Medication 3
Name of Medication			
Expiry Date			
Dose/frequency			
Durations (dates)	From: To:	From: To:	From: To:
Route of Administration			
Administration	By self ☐ Requires assistance ☐	By self ☐ Requires assistance ☐	By self ☐ Requires assistance ☐
Storage Instructions	Stored at School ☐ Kept by self ☐ Refrigerate ☐ Keep out of sunlight ☐ Other ☐	Stored at School ☐ Kept by self ☐ Refrigerate ☐ Keep out of sunlight ☐ Other ☐	Stored at School ☐ Kept by self ☐ Refrigerate ☐ Keep out of sunlight ☐ Other ☐

Section E – Authority to Act

I/we authorise school staff to provide health care support for my/our child in accordance with the above plan and/or the attached plan from a medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Guardian: _____

Date: _____

Medical Practitioner: _____

Date: _____

Review Date: _____

Section F – Additional Required Forms/Plans

If you child has one of the following medical conditions, additional information will be required to ensure that we can carry out our duty of care in line with the *Management of Students with Specialised Health Needs* Department of Education and Training Policy and Procedure.

Severe Allergy/Anaphylaxis – Action Plan for Anaphylaxis for use with EpiPen
Minor & Moderate Allergies – Action Plan for Allergic Reactions
Diabetes – Emergency Health Plan & Individual Health Plan
Seizures – Epilepsy Management Plan
Asthma – Action Plan for Asthma

Please attach any further documentation that you feel will assist in the care of your child whilst at school.

If you wish to speak with the First Aid Officer directly, please call 07 5525 9431

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

ACTION PLAN FOR Anaphylaxis

For EpiPen® adrenaline (epinephrine) autoinjectors

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by Dr or NP:

_____

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

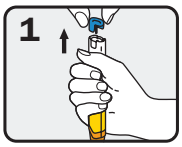
Signed:

_____

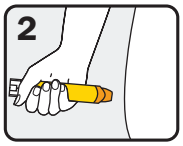
Date: _____

Action Plan due for review: _____

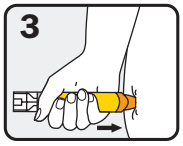
How to give EpiPen®



Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE



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



PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds

REMOVE EpiPen® and gently massage injection site for 10 seconds

Instructions are also on the device label

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy - freeze dry tick and allow to drop off
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr adrenaline autoinjector
- Give other medications (if prescribed).....
- Phone family/emergency contact

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

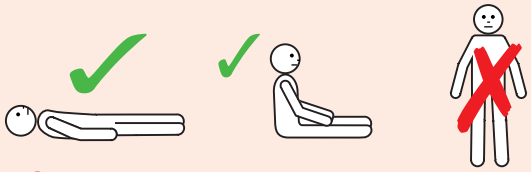
WATCH FOR ANY ONE OF THE FOLLOWING SIGNS OF ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

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

ACTION FOR ANAPHYLAXIS

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

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



2 Give EpiPen® or EpiPen® Jr adrenaline autoinjector

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

4 Phone family/emergency contact

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

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

If in doubt give adrenaline autoinjector

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

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

Asthma reliever medication prescribed: ☐ Y ☐ N

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www.allergy.org.au

ACTION PLAN FOR Allergic Reactions

Name: _____

Date of birth: _____

Confirmed allergens:

Family/emergency contact name(s):

_____

_____

Work Ph: _____

Home Ph: _____

Mobile Ph: _____

Plan prepared by Dr or NP:

_____

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

Signed:

_____

Date: _____

Action Plan due for review: _____

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

For people with severe allergies (and at risk of anaphylaxis) there are ASCIA Action Plans for Anaphylaxis, which include adrenaline (epinephrine) autoinjector instructions

Instructions are also on the device label

SIGNS OF MILD TO MODERATE ALLERGIC REACTION

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

ACTION FOR MILD TO MODERATE ALLERGIC REACTION

- For insect allergy - flick out sting if visible
- For tick allergy - freeze dry tick and allow to drop off
- Stay with person and call for help
- Give other medications (if prescribed).....
- Phone family/emergency contact

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

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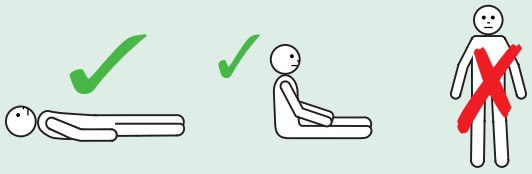
- Pale and floppy (young children)

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, 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

EMERGENCY HEALTH PLAN

NAME:

DATE OF BIRTH

HYPOGLYCAEMIA

Blood Glucose Level (BGL) Below 4 mmol/L

Insert student's photo

MILD-MODERATE

SIGNS AND SYMPTOMS

- Shaky
- Pale sweating
- Looks unwell
- Complaining of headache or feeling hot
- Irritable/Argumentative
- Mood change

DO NOT LEAVE UNATTENDED OR SEND TO OFFICE/SICKBAY

TREATMENT

- Check student's blood glucose level (if able).

IF IN DOUBT TREAT

- Give *1 Popper 125ml*
  (Or *5 jelly beans* or *3 teaspoons sugar* or *150ml lemonade*)
- Retest BGL in 15 mins. Clean fingers if possible.
- If below 4 mmol/l give another *popper* and wait 15 minutes. Retest blood glucose level.
- Once above 4 mmol/l, if due to eat within 30 minutes to eat as usual. If not, give slow acting carbohydrate such as *muesli bar, 2 plain biscuits* or as provided in hypo box.

SEVERE

SIGNS AND SYMPTOMS

- Unable to swallow, drowsy (e.g Can't suck on a popper)
- Confused or Disorientated
- Unconscious
- Having a seizure

TREATMENT

- DO NOT GIVE FOOD OR DRINK
- DO NOT LEAVE UNATTENDED
- If unconscious, place the student in the recovery position (on side) and check his/her airway is clear.
- Phone ambulance **DIAL 000 / 112 (mobile)**
- Ring parents once ambulance has been called

WHEN CALLING AN AMBULANCE

- State it is a **Diabetes emergency**
- School's address:

PARENT

Mum
Dad:
Home
Mobile

EQUIPMENT LOCATION

To be kept with or in close proximity to student

- Hypo Kits
- BG Meter
- Health plans

REMEMBER

- Record the event
- Restock Hypo kits and /or medication used

In the event of an emergency I authorise school personnel to follow this management plan as outlined.

Parent/ Carer name: Signature: date:

Plan developed by: Signature: date:

EMERGENCY HEALTH PLAN

NAME:

DATE OF BIRTH

HYPERGLYCAEMIA

Blood Glucose Level (BGL) above 15 mmol/L

Student is Well

SIGNS AND SYMPTOMS

- **Excessive thirst**
- **Going to the toilet frequently**
- **Tired**

ACTION

- Allow water and toilet privileges
- Student should **NOT** be made to exercise
- If Student becomes unwell contact parents and/or follow **Student is Unwell** pathway

PARENT

Mum
Dad
Home
Mobile

WHEN CALLING AN AMBULANCE

- State it is a **Diabetes emergency**
- School's address:

REMEMBER

Record event

Student is Unwell

SIGNS AND SYMPTOMS

- **Nausea and/or abdominal pain**
- **Vomiting**
- **Rapid laboured breathing**
- **Sweet-smelling breath**

ACTION

- **DO NOT LEAVE UNATTENDED**
- Phone ambulance **DIAL 000 / 112 (mobile)**
- Ring parents once ambulance has been called

In the event of an emergency I authorise school personnel to follow this management plan as outlined.

Parent/ Carer name: _____Date: _____
Signature: _____
Plan developed by: _____
Signature: _____Date: _____

DIABETES INDIVIDUAL HEALTH PLAN

PLACE PHOTO HERE		
	STUDENT'S NAME	
	DATE OF BIRTH	
	YEAR LEVEL	
	TEACHER	
	PARENT SIGNATURE	
	HEALTH PROFESSIONAL NAME/QUALS/SIGNATURE	
	DATE	

EMERGENCY CONTACT NUMBERS (If unconscious call 000 first)

	NAME	NUMBER
1	*Parents*	
2		
3	*Diabetes Team*	

HYPOGLYCAEMIA (Hypo) = LOW BLOOD GLUCOSE LEVEL (BGL)

MUST TREAT IMMEDIATELY IF BGL < _____ mmols/L

(Student's name)		**specific warning signs when experiencing hypoglycaemia**	
☐	Shaky	☐	Irritable
☐	Pale	☐	Complaining of headache or feeling hot
☐	Dizzy	☐	Mood change eg becoming tired/withdrawn
☐	Looks unwell	☐	Crying
☐	Sweating	☐	Argumentative
Other specific information: *Personalise to student*			

HYPO ACTION PLAN
Remain with student at all times

1. Test BGL with student's meter AND TREAT IMMEDIATELY.
   If in doubt or student does not have a meter – STILL TREAT with ONE of the following **fast acting** glucose food/drinks. DO NOT ATTEMPT IF STUDENT IS UNCONSCIOUS/FITTING. RING 000.
   - *List sample foods/drinks*
   -
3. Give ONE of the following **slow acting** glucose food/drinks
   - *List sample foods/drinks*
   -
2. Retest BGL after 15-20 minutes. If BGL is still < _____, repeat fast acting glucose food/drink until student's BGL is > _____.

STUDENT SHOULD NEVER BE SENT TO SICK BAY ON THEIR OWN OR LEFT UNATTENDED UNTIL FULLY RECOVERED FROM HYPOGLYCAEMIA EVENT. PHONE PARENTS.

IF STUDENT IS UNCONSCIOUS/FITTING (SEVERE HYPOGLYCAEMIA)

1. Lay student on side.
2. DO NOT give any food or fluids by mouth.
3. IMMEDIATELY phone 000 for an ambulance and cite **DIABETES EMERGENCY.**
4. Phone parents.

HYPERGLYCAEMIA = HIGH BLOOD GLUCOSE LEVEL (BGL OVER 15 MMOLS/L)

1. If BGL > 15 mmols/L student needs extra water and toilet privileges.
2. Student should not be made to exercise
3. If student has a high BGL and feels unwell, develops nausea, vomiting or abdominal pain, parents MUST be contacted as the student needs to go home.

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:

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:

Asthma care plan for education and care services

Photo of child (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.

Date of approval: July 2014
Approved by: CEO Asthma Australia
Date of review: July 2016

AA Care Plan for Ed-Care-Serv 0714
July 16, 2014 9:14 PM

PLEASE PRINT CLEARLY

Child's name Date of birth

Managing an asthma attack

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

Daily asthma management

This child's usual asthma signs

- ☐ 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 child's asthma (eg exercise, colds/flu, smoke) — please detail:*

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

Medication plan

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

Name of medication and colour	*Dose/number of puffs*	*Time required*

Doctor

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