STUDENT ALLERGY RECORD

ELEMENT 4.4 RECORDS MANAGEMENT

St Monica's School

STUDENT NAME:		GENDER	**M**	**F**
ADDRESS:		DOB		
TEACHER:		YEAR LEVEL		
DOCTOR:		PHONE NO:		

EMERGENCY CONTACT 1	**EMERGENCY CONTACT 2**
Name:	**Name:**
Address:	**Address:**
Relationship:	**Relationship:**
Phone Number:	**Phone Number:**

ALLERGY	
Symptoms	**Triggers**

Medication Requirements		
NAME OF MEDICATION:	**METHOD OF ADMINISTERING THE MEDICATION**	**DOSAGE/TIMES**

Note the name of the Parent/Guardian requesting the Allergy Plan for a Student at St Monica's School.

Name:

Relationship: Contact Phone No.

I consent to the plan outlined being implemented as required: YES / NO
(circle one)

67 Lorrimer Street, OAKEY QLD 4401
Ph: 07 46 911 067 Fax: 07 46 911 416 Email: oakey@twb.catholic.edu.au

My Child's Allergy First Aid Plan

Step One

Step Two

Step Three

When and at what stage should an Ambulance be called:

Parent/Guardian/Carer Statement

I, _____ authorise St Monica's School staff to follow the preferred Allergy First Aid Plan and assist my child with taking Allergy medication should they require help. I will notify you in writing if there are any changes to these instructions. Please contact me if my child requires emergency treatment or if my child regularly has Allergy symptoms at school.

Signature of Parent/Guardian/Carer: _____

Date of Authority: _____

Doctor's Statement

I _____ verify that I have read the preferred Allergy First Aid Plan and agree with its implementation.

Signature of Doctor: _____ Date: _____

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