



Medical Conditions Management Plan

Family name:

Participant:

This document is to be used when participants have been identified as, or have a suspected medical condition requiring additional management, precautions and documentation.

At all times the Provider, Outside Service Providers and Volunteers of the service will follow the Kat's Care Services - Dealing with Medical Conditions Policy and Procedures provided to you at the time of enrolment and available at the provider's premises or on the service website: www.katscareservices.com.au

Parents/guardians or participants are required to provide the service with a copy of the written medical management plan or action plan from a medical practitioner where there is one in place.

The following plan is to be completed with your provider prior to starting in care and reviewed annually or if changes are made by your practitioner/specialist:

1. Medical Communications Plan
2. Medical conditions, management/action and minimisation plan.

Where medications are administered the Medications Record form is to be completed.



Document Name	Version Number	Date of Issue	Review Date
KCS_Medical Conditions Management Plan.	1.0.0	14 April 2019	As required

Place copy of child's individual action plan here as provided by the treating Doctor



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

ACTION PLAN FOR

Anaphylaxis



Name: _____
Date of birth: _____



Confirmed allergens: _____

For use with EpiPen® adrenaline autoinjectors

MILD TO MODERATE ALLERGIC REACTION

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
- Abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks.**
- Stay with person and call for help
- Locate EpiPen® or EpiPen® Jr
- Give other medications (if prescribed)
- Dose:
- Phone family/emergency contact

EXAMPLE ONLY

actions may
phylaxis
gns of Anaphylaxis

Work Ph: _____
Home Ph: _____
Mobile Ph: _____

Plan prepared by: _____
Dr: _____
Signed: _____
Date: _____

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

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

ACTION

- 1 Lay person flat. Do not allow them to stand or walk. If breathing is difficult allow them to sit.**
- 2 Give EpiPen® or EpiPen® Jr**
- 3 Phone ambulance*- 000 (AU), 111 (NZ), 112 (mobile)**
- 4 Phone family/emergency contact**
- 5 Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)**

If in doubt, give adrenaline autoinjector

After giving adrenaline:

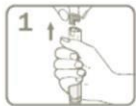
- Commence CPR if there are no signs of life
- Give asthma medication if unsure whether it is asthma or anaphylaxis

EpiPen® is generally prescribed for adults and children over 5 years.

EpiPen® Jr is generally prescribed for children aged 1-5 years.

*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

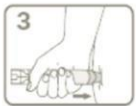
How to give EpiPen®



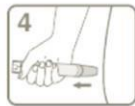
Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE.



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®. Massage injection site for 10 seconds.

Instructions are also on the device label and at www.allergy.org.au/health-professionals/anaphylaxis-resources

© ASCIA 2013. This plan was developed by ASCIA

Additional information _____

Note: This is a medical document that can only be completed and signed by the patient's treating medical doctor and cannot be altered without their permission.

Document Name	Version Number	Date of Issue	Review Date
KCS_Medical Conditions Management Plan.	1.0.0	14 April 2019	As required

Medical Communications Plan

Medical Risk Minimisation Plans should be reviewed regularly, when there are any updates from the Doctor or at least annually between the Provider/ Parent/Guardian and the Participant.

Name of Participant:

Parent/Guardian Name:

Provider Name Katrina Thompson trading as Kat's Care Services

Date of commencement service:

1. Date reviewed:

2. Date reviewed:

3. Date reviewed:

4. Date reviewed:

Medical conditions, management/action and minimisation plan

Medical Condition/allergy:	Reaction	Management	How will the risk be managed?

Document Name	Version Number	Date of Issue	Review Date
KCS_Medical Conditions Management Plan.	1.0.0	14 April 2019	As required

I give permission for my Provider to administer emergency medical as per medical plan.
Parent/Guardian signature: _____ Educator signature: _____



Document Name	Version Number	Date of Issue	Review Date
KCS_Medical Conditions Management Plan.	1.0.0	14 April 2019	As required