**Anaphylaxis incident reporting template for children’s education and care (including outside schools hours care) services**

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| --- | --- |
| **Child’s name:** | **Child’s Date of birth:** |
| **Date of allergic reaction:** | **Time of allergic reaction**: |
| **Name/s and position/s of staff member/s who provided first aid** |  |
| **Symptoms observed** (tick all symptoms that were observed) | [ ]  Swelling of lips, face, eyes[ ]  Tingling mouth[ ]  Hives or welts[ ]  Abdominal pain, vomiting [ ]  Difficult/noisy breathing[ ]  Swelling of tongue[ ]  Swelling/tightness in throat[ ]  Wheeze or persistent cough[ ]  Difficulty talking or hoarse voice[ ]  Persistent dizziness or collapse[ ]  Pale and floppy[ ]  Other (please specify): |
| **Where was the child when the allergic reaction occurred?** |  |
| **Where was the child treated?** |  |
| **What is the likely cause of the allergic reaction?** |  |
| **Was the child exposed to a known allergen?****If yes, what allergen?****If yes, how did this occur?** | [ ]  Yes[ ]  No [ ]  Not surePlease specify:Please specify: |
| **Does the child have an ASCIA Action Plan?** | [ ]  ASCIA Action Plan for Anaphylaxis (red)[ ]  ASCIA Action Plan for Allergic Reactions (green)[ ]  ASCIA Action Plan for Drug (medication) Allergy[ ]  No[ ]  Not sure |
| **Was the child’s ASCIA Action Plan followed?** | [ ]  Yes[ ]  No (Please specify):[ ]  Child did not have an ASCIA Action Plan[ ]  ASCIA First Aid Plan for Anaphylaxis was followed[ ]  Other (please specify) |
| **During the allergic reaction, was the child positioned to either be laying flat or sitting with their legs outstretched or if a baby, the baby was held horizontal across the adult’s body (so that they are not upright)?** | [ ]  Yes [ ]  No (please specify): |
| **Was the child’s prescribed adrenaline injector given?****If not, why?** | [ ]  Yes [ ]  No [ ]  Child does not have a prescribed adrenaline injector[ ]  Expired [ ]  Misfired [ ]  Not close by [ ]  Other (please specify): |
| **Was a general use (not prescribed to a child) adrenaline injector used?****If so, why?** | [ ]  Yes [ ]  No[ ]  Child has not been diagnosed with an allergy [ ]  Child has not been prescribed an adrenaline injector but has ASCIA Action Plan for Allergic Reactions (green)[ ]  Second dose needed [ ]  Child’s prescribed device was expired [ ]  Child’s prescribed device misfired [ ]  General use device was closer to hand than prescribed device [ ]  Other (please specify): |
| **How long after observing anaphylaxis symptoms was the adrenaline injector given?** | [ ]  Less than 5 minutes[ ]  Between 5-10 minutes[ ]  Between 10-20 minutes[ ]  Other (please specify): |
| **What other medications were given by CEC service staff?** | [ ]  Antihistamine (e.g. Claratyne®, Zyrtec®)[ ]  Asthma reliever (e.g. Ventolin®)[ ]  Additional adrenaline doses[ ]  Other (please specify): |
| **Was an ambulance called?** | [ ]  Yes[ ]  No (please specify): |
| **How was the child transported to the ambulance?** | [ ]  Walked[ ]  Carried[ ]  Stretchered[ ]  Other (please specify): |
| **Was the child transported to hospital?****If yes:****Was the child’s ASCIA Action Plan taken with the child?****Was the child’s prescribed adrenaline injector taken with the child?** | [ ]  Yes The name and role of the person who accompanied the child:[ ]  No (please specify):[ ]  Yes [ ]  No[ ]  Yes [ ]  No |
| **Was the parent/emergency contact called?** | [ ]  Yes[ ]  No (please specify): |
| **Please provide any other information in relation to this incident** |  |

Full name of the person completing this record:

Signature:

Position:

Date:

Has this record been made available to the parent/family and doctor of the child?

Date provided to family:

Date provided to doctor: