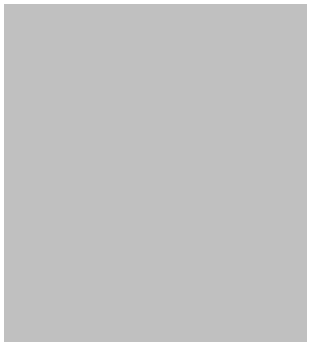

Name: Date of birth: DD / MM / YYYY

Confirmed allergen(s):

Family/emergency contact(s):

1. Mobile:

2. Mobile:

Plan prepared by: (doctor or nurse practitioner)
who authorises medications to be given, as consented by the patient or parent/guardian, according to this plan.

Signed: Date: DD / MM / YYYY

Antihistamine: Dose:

This plan does not expire but review is recommended by: DD / MM / YYYY

MILD TO MODERATE ALLERGIC REACTIONS

SIGNS:

- Swelling of lips, face, eyes
- Hives or welts
- Tingling mouth
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