

Individual Healthcare Plan (IHP) – Allergy Management

Westfield Primary School



I. Pupil Information

Name	
Date of birth	
Year Group/Class	
Parent/Carer Name(s)	
Contact Numbers	
Email	
GP/Medical Practice	
Diagnosis Date	
Consultant / Specialist (if applicable)	

2. Allergy Details

Allergy Type(s): (e.g., nuts, dairy, egg, insect sting, latex, medication)

Severity Level: ☐ Mild ☐ Moderate ☐ Severe / Anaphylaxis

Known Triggers:

Typical Symptoms:

- *Mild:*
- *Moderate:*
- *Severe / Anaphylaxis:*

3. Medication & Equipment

- **Prescribed Adrenaline Auto-Injectors (AAIs):**
 - Brand:
 - Dose:
 - Quantity in school:
 - Expiry dates:
- **Location of Pupil's AAIs:**
- **Spare School AAIs (Benedict's Law requirement):**
 - Location(s):
 - Checked monthly by:
- **Other Medication (e.g., antihistamines):**

4. Emergency Response Plan

If mild symptoms occur:

- Administer antihistamine (if prescribed)
- Monitor pupil
- Inform parents/carers

If severe symptoms or anaphylaxis occur:

1. **Administer AAI immediately**
2. **Call 999 - state "anaphylaxis"**
3. Lay pupil flat (or sit up if breathing is difficult)

4. Administer second AAI after 5 minutes if symptoms persist
5. Inform parents/carers
6. DSL and Senior Allergy Lead complete incident record
7. Review IHP within 48 hours

5. Risk Reduction Measures

Classroom Arrangements	
Catering / Lunchtime Arrangements	
Curriculum Activities (including food-based learning)	
Trips, Clubs & Residential	

6. Inclusion & Reasonable Adjustments

7. Staff Responsibilities

- **Named Senior Allergy Lead:**
- **Class Teacher:**
- **Support Staff:**
- **Catering Lead:**
- **Staff trained in AAI use:**

8. Parent/Carer Agreement

I confirm that the information provided is accurate and that I will update the school immediately if my child's needs change.

Signature:

Date:

9. School Agreement

Westfield Primary School agrees to follow this IHP, ensure staff training, maintain spare AAls, and uphold statutory duties under Benedict's Law and KCSIE.

Headteacher Signature:

Senior Allergy Lead Signature:

DSL Signature:

Date:

10. Review Schedule

- **Initial Plan Date:**
- **Review 1:**
- **Review 2:**
- **Additional review following incident:** Yes / No
 - **Date:**