SELINSGROVE AREA SCHOOL DISTRICT

Action Plan for Bee/Insect Sting Allergies

Name of Student: _____ Grade: _____ School Year: _____

Teacher: _____

Dear Parent/Guardian:
It is indicated on your child's health record or student health form that he/she has a bee/insect sting allergy. In order to provide the best medical care for your child, we request that you complete this form and return it to the School Nurse immediately.

1. **Symptoms student has experienced in the past: (Please check all that apply.)**

_____Swelling/redness of the sting area	_____Hives
_____Swelling of lips, tongue, throat	_____Hoarseness
_____Skin flushed all over the body	_____Wheezing
_____Dizziness	_____Breathing difficulty
_____Nausea	_____Thickened speech
_____Vomiting	_____Extreme weakness
_____Abdominal cramps	_____Blue color of skin/lips
_____Itching all over the body	_____Other:_____

2. **Date of last bee/insect sting (month & year) _____ Epipen required? (Y/N) _____**
3. **Has your student ever needed treatment at a clinic/hospital for an allergic reaction? (Y/N) _____**
   Please describe: _____

4. **In the event of a bee/insect sting, please provide the exact <u>plan of care</u> to be carried out:**

   Medications needed:
   Name and Dosage of Medication: _____
   Name and Dosage of Medication: _____
   May dose be repeated: Yes _____ No_____
   Special Instructions: _____
   _____

   ****If an EpiPen is listed in the <u>plan of care</u>, administer the Epipen (Choose one):**

   _____ Immediately after a bee/insect sting <u>regardless</u> if symptoms of Anaphylaxis are present

   _____ Only if signs/symptoms of Anaphylaxis are present

***Is student permitted to carry and self-administer the epinephrine auto-injector? Yes_____ No_____**

Physician's Name and Signature _____ Date_____

I hereby give my permission for the medication(s) listed above to be given to my child by the School Nurse or the designee of the nurse. I relieve the Selinsgrove Area School Board and its employees of liability in the administration of this medication. I agree to allow the school nurse or designee to contact the prescribing physician concerning medication(s) if necessary.

Signature of Parent _____ Date _____
Student Signature _____ Date_____

Revised 9/2020