Hollidaysburg Area School District
BEE STING/INSECT BITE CARE PLAN

Student: ________________________________Grade: ________ School Year: _______________

Goal #1: Student will not experience any bee or insect reaction at school/school activity during the current school year by avoiding and reporting any bees/insects seen in or around the school.
Goal #2: If a bee/insect bite does occur at school, the episode will be controlled by following the outlined care plan to avoid any further medical complications.

In Case of emergency, contact:

1. **________________________________Phone: ____________ Relationship:___________**
2. **________________________________ Phone:______________ Relationship:__________**

The following is standard school district procedure for anyone stung by a bee or insect:

1. Remove stinger if visible
2. Apply sting kill swab
3. Apply ice pack
4. Observe the student closely for 15-20 minutes. Monitor for an additional 15-20 minutes in the classroom.

PARENTS, please make your child aware of his/her bee sting allergy and of the need to inform someone of having been stung by a bee/insect.

Please check the status of your child's reaction to bee stings or insect bites:

______My child has a localized reaction (swelling or redness at the site of the sting).

______My child has a severe reaction (difficulty breathing, severe swelling, numbness, hives, or itching).
Describe your child' reaction: ____

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If your child has a severe reaction, has he/she:
______Begun desensitization treatment (allergy shots)
______My child has not been desensitized
______Has an anaphylactic kit (Epipen) prescribed

If your child has a reaction to bee stings or insect bites please check the procedures to follow:
______Follow routine school district policy on bee stings/insect bites.
______Notify parent at once.
______Give medication as prescribed by my child's physician (The parent must provide written orders from the physician). Name of Medication:____
______My child's physician has ordered an anaphylactic kit (Epipen) to be administered by the school nurse or school personnel.
If medication is needed, the attached medication form must be completed by the PHYSICIAN

Other Instructions:

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Parent Signature: ____Date:________________________

Physician Signature: ____Date: ________________________