# Mount Pleasant Central School District

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Thornwood, NY 10594

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# Bee Sting Medication Form

Student:_____Grade:_____School Contact:_____DOB:_____

Asthmatic: ☐ Yes ☐ No (increased risk for severe reaction) Severity of reaction(s):_____

Mother: _____MHome #: _____ MWork #: _____ MCell #:_____

Father: _____ FHome #: _____ FWork #: _____FCell #: _____

Emergency Contact: _____Relationship: _____Phone: _____

**SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:**

- MOUTH — Itching & swelling of lips, tongue or mouth
- THROAT — Itching, tightness in throat, hoarseness, cough
- SKIN — Hives, itchy rash, swelling of face and extremities
- STOMACH — Nausea, abdominal cramps, vomiting, diarrhea
- LUNG — Shortness of breath, repetitive cough, wheezing
- HEART — "Thready pulse", "passing out"

Student Photo

The severity of symptoms can change quickly – it is important that treatment is give immediately.

STAFF MEMBERS INSTRUCTED: ☐ Classroom Teacher(s) ☐ Special Area Teacher(s)
☐ Administration ☐ Support Staff ☐ Transportation Staff

**TREATMENT:** 1. Remove stinger if visible; apply ice to area. 2. Rinse contact area with water.

Treatment should be initiated ☐ with symptoms ☐ without waiting for symptoms
Benadryl ordered: ☐ Yes ☐ No Give _____ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ☐ Yes ☐ No Special instructions:_____

**IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.**

Preferred Hospital if transported: _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

**Transportation Plan:** ☐ Medication available on bus ☐ Medication NOT available on bus ☐ Does not ride bus
Special instructions:_____

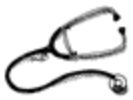
Healthcare Provider: _____Phone:_____
Written by: _____Date:_____
☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff _____

*This plan is in effect for the current school year and summer school as needed.*

**MOUNT PLEASANT CENTRAL SCHOOL DISTRICT**

**Medication Administration Order Form**
**for School and School Activities**



Student Name: _____ DOB/Grade: _____ Teacher/HR: _____

Parent/Guardian Name: _____ Telephone: _____

## Orders To Be Completed By Health Care Provider

| Diagnosis (must be included) and Medication Name | Dose | Route | Frequency (Time) | Sign, Symptom or Situation (if prn) | ☑ applicable boxes below |
|---|---|---|---|---|---|
| | | | | | ☐ Independent Student<br>☐ Supervised Student<br>☐ Nurse Dependent |
| | | | | | ☐ Independent Student<br>☐ Supervised Student<br>☐ Nurse Dependent |
| | | | | | ☐ Independent Student<br>☐ Supervised Student<br>☐ Nurse Dependent |

***For any medication that is considered "Rapid Administration" (e.g. inhalers, diabetic medications) please complete the NYSCSH Provider Attestation and Parent Permission Form***

**Prescriber: Please choose level of supervision needed for each medication ordered**

| | |
|---|---|
| **Independent Student** | I attest that this student has demonstrated to me that he/she can self-administer the medication(s) noted above safely and effectively, and may carry and use this medication independently at any school/school sponsored activity with no supervision by school staff. **This code cannot be used for Grades K-2.** |
| **Supervised Student** | I attest that this student is self-directed regarding his/her medication. He/She understands the purpose, name, amount, dose, timing and effect of taking or not taking the medication. Recognizes what medication looks like and if/when to refuse to take it. The **school nurse**, or **designated person** in the absence of the school nurse, will assist the student in taking his/her medication. Medication is kept in the Health Office. |
| **Nurse Dependent Student** | I attest that this student is non-self-directed. A nurse **must administer** the student's medication. |

**Name/Title of Licensed Prescriber (Print)** _____

Stamp

**Prescriber's Signature** _____ **Date** _____ **Phone** _____

## To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my Health Provider. I will furnish the medication in the **original pharmacy container**, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. I will deliver medication to Health Office if my child is not deemed independent.

In addition, parent permission along with provider consent is required for students to self-administer and self- carry medication. Students identified with this designation are independent in taking their medication at school and require no supervision by the nurse or school staff. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable.

**A new order form is required for each new school year.**

**Parent/Guardian Signature**_____ **Date** _____ **Phone** _____

Mount Pleasant Central School District

## PROVIDER ATTESTATION AND PARENT PERMISSIONS

## FOR INDEPENDENT MEDICATION CARRY AND USE

**Directions for the Health Care Provider:** This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently carry and use their medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name: _____ DOB: _____**

**Health Care Provider Permission for Independent Use and Carry**

I attest that this student has demonstrated to me that he or she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____which requires rapid administration of _____
  (State Diagnosis) (Medication Name)

Signature: _____ Date: _____

**Parent/Guardian Permission for Independent Use and Carry**

I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

**Please return to School Nurse:**

| School Nurse: | | School: |
|---|---|---|
| Phone #: | Fax: | Email: |
| | | |