

YOAKUM ISD SCHOOL HEALTH SERVICES

INSECT & BEE STING ALLERGY

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_

Asthmatic:  Yes  No (increased risk for severe reaction) Severity of reaction(s): \_\_\_\_\_

Mother: \_\_\_\_\_ MHome #: \_\_\_\_\_ MWork #: \_\_\_\_\_ MCell #: \_\_\_\_\_

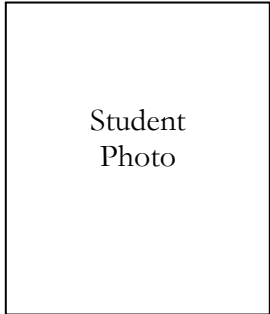
Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_

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"

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



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

TREATMENT: Remove stinger if visible, apply ice to area. 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.

Revised 1/14