



BEE STING ALLERGY



Sample

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.**

Student
Photo

STAFF MEMBERS INSTRUCTED:

- ☐ Administration ☐ Classroom Teacher(s) ☐ Special Area Teacher(s)
☐ Support Staff ☐ 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 1/08

EPI PEN and EPI PEN JR Order

I / We hereby request that the Meyersdale Area School District, through its appropriate personnel, administer a physician's prescribed medication to our child, as described below. I / We further hereby release and hold harmless, the Meyersdale Area School District and its employees, from any liability for injury or damages as a result of such administration of medicine.

*** The ambulance will be called after administration of an EPI PEN.**

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Parent/Guardian: Initial here if you want your child to carry his/her Epi Pen on their person _____

Consistent with the above request by the parents of the below identified child, I hereby request that the Meyersdale Area School District allow its appropriate personnel to administer a medication which I have prescribed, as follows:

DR. – Please be specific on the order for the Epi Pen – If you want Benadryl administered first and then re-assessment of patient please list that as medication number 1 and then follow with EPI as medication #2. Please note specific S&S that require admin of EPI for this child. If the allergy is severe and you want both administered together please note that as well. Please be specific on your orders. Thank you so much.

Child's name: _____

Name of Medication: 1. _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

Possible Side Effects or Contraindications: _____

Name of medication: 2. _____

Dosage: _____

Time to be Administered: _____

Purpose of Medication: _____

Possible Side Effects or Contraindications: _____

Termination date for Administering the Medication: _____

Diagnosis: _____

Other medication prescribed by the physician that the student is taking outside of school hours: _____

Curtailement of specific school activity: _____
(sports, shop, lab, gym, EtC)

DATE

PHYSICIAN'S SIGNATURE

Initial here as well if you feel this patient should carry their Epi Pen with them during school hours. _____