

Pine Grove Area School District

SCHOOL HEALTH SERVICES
2026-2027 School Year
Bee Sting Allergy Emergency Action Plan

Name of Student

Date of Birth

Medical Problems

Food Allergies

Medication Allergies

Step 1: Treatment

Remove stinger if present / Clean area with soap and water / Apply ice to sting area

Symptoms	Give checked medication			
If student has been stung, but no symptoms	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Mouth (itching, tingling, swelling of lips/tongue/mouth)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Skin (hives, itching, rash, swelling of face/extremities)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Gut (nausea, abdominal cramps, vomiting, diarrhea)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Throat (tightness, hoarseness, hacking cough)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Lung (shortness of breath, coughing, wheezing)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Heart (weak/thready pulse, low blood pressure, fainting, pale)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
If reaction is progressing (several of the above areas affected)	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____
Other _____ _____	☐ EpiPen IM	☐ Diphenhydramine (Benadryl) 25-50 mg po	☐ Albuterol inhaler 2 puffs	☐ Other _____

Step 2: Emergency Calls

- 1) If EpiPen is given or other medications are not effective, call 911 for ambulance transport.
- 2) Contact Parent/Guardian as listed on Student Update form (copy attached).

Physician's Signature

Date

Physician's Name Printed

Physician's Phone Number

Signature of Parent/Guardian

Date



Pine Grove Area School District



SCHOOL HEALTH SERVICES

2026-2027 School Year

Medication Order

It is this school district's policy to request that medications be given before or after school hours. When this is not possible, prior to receiving the medication (prescription or non-prescription) at school, each student must provide the school nurse with a Medication Order signed by a licensed prescriber and the student's parent/guardian. All medications must be in the original container. This form is valid only for the current school year.

Name of Student

Date of Birth

Medical Problems

Allergies

Name of Medication

Dosage

Route

Diagnosis / Reason for Taking

Frequency / Time of Administration

Discontinuation Date

Specific Directions

☐ Student may carry and self-administer EpiPen

☐ Student may carry and self-administer inhaler

Additional Information (Serious reactions, side effects, contraindications, etc.)

Other Medications Currently Taking

Licensed Prescriber's Signature

Date

Licensed Prescriber's Name Printed

Licensed Prescriber's Phone Number

I give permission for the above medication to be given to my child during school hours. I understand that the medication will be given according to my child's licensed prescriber's directions. I do hereby release, discharge, and hold harmless the Pine Grove Area School District, its agents and its employees from any and all liability and claim whatsoever for the administration of the above medication to the above named child.

Signature of Parent/Guardian

Date

Pine Grove Area School District

SCHOOL HEALTH SERVICES

2026-2027 School Year
Epi-Pen Contract

Name of Student

Date of Birth

I give permission for my child to carry and administer their Epi-Pen. Thus, the school is not responsible for ensuring the medication is taken. The school district and its employees are relieved of any responsibility for the benefits or consequences of the Epi-Pen.

Signature of Parent/Guardian

Date

I have received and understand the instructions from my physician/CRNP/PA on proper safety precautions for the handling and disposal of my Epi-Pen and agree to abide by the following rules:

I will follow the directions for the use of my Epi-Pen as ordered by my physician/CRNP/PA.

I will never allow another student to have access to my Epi-Pen.

I will notify the school nurse each time I use my Epi-Pen.

I understand that if I do not follow these rules, I will lose the privilege to carry my Epi-Pen.

Signature of Student

Date

The above named student has demonstrated the ability to correctly self-administer his/her prescribed Epi-Pen.

Signature of School Nurse

Date

Pine Grove Area School District

SCHOOL HEALTH SERVICES

2026-2027 School Year
Asthma Inhaler Contract

Name of Student

Date of Birth

I give permission for my child to carry and administer their inhaler. Thus, the school is not responsible for ensuring the medication is taken. The school district and its employees are relieved of any responsibility for the benefits or consequences of the inhaler.

Signature of Parent/Guardian

Date

I have received and understand the instructions from my physician/CRNP/PA on proper safety precautions for the handling and disposal of my inhaler and agree to abide by the following rules:

I will follow the directions for the use of my inhaler as ordered by my physician/CRNP/PA.

I will never allow another student to have access to my inhaler.

I will notify the school nurse each time I use my inhaler.

I understand that if I do not follow these rules, I will lose the privilege to carry my inhaler.

Signature of Student

Date

The above named student has demonstrated the ability to correctly self-administer his/her prescribed asthma inhaler.

Signature of School Nurse

Date