



**Brecksville-
Broadview Heights
City School District**

Brecksville-Broadview Heights City Schools Board of Education Office

6638 Mill Road, Brecksville, Ohio 44141

Jeffrey D. Harrison
Superintendent

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Treasurer/CFO

Insect Sting Allergy Action Plan

Student Name _____ Date of Birth _____ Grade ____ School Year _____

Allergy To:

Asthmatic: __ Yes __ No

TREATMENT (To be completed by physician) A medication form must be filled out for each medication

SYMPTOMS:

**GIVE CIRCLED MEDICATION (TO BE COMPLETED BY
A PHYSICIAN)**

If a sting has occurred, but NO SYMPTOMS

EpiPen

Antihistamine

MOUTH: Itching, tingling, or swelling of lips, tongue

EpiPen

Antihistamine

SKIN: Hives, rash, swelling of face or extremities

EpiPen

Antihistamine

GUT: Nausea, cramping, vomiting, diarrhea

EpiPen

Antihistamine

THROAT* : Tightening of throat, hoarseness, cough

EpiPen

Antihistamine

LUNG* : Shortness of breath, coughing, wheezing

EpiPen

Antihistamine

HEART* : Thready pulse, low blood pressure, fainting

EpiPen

Antihistamine

OTHER:

EpiPen

Antihistamine

**If reaction is progressing or several of the above areas are
affected**

EpiPen

Antihistamine

Potentially life-threatening. 9-1-1 WILL BE CALLED IF EPIPEN IS ADMINISTERED

Epinephrine (circle): EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg Auvi-Q 0.15 mg Auvi-Q 0.3 mg

Antihistamine (Name/Dose/Route):

EMERGENCY CONTACTS

Name/Relationship to Student

Phone number(s)

1

1. 2.

2

1. 2.

3

1. 2.

Physician	
I give permission for school personnel to follow this plan and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and corresponding forms. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.	
Parent/Guardian Signature	Date
Physician's Signature	Date
Nurse's Signature	Date

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES AND USES PRESCRIBED EPIPENS IN SCHOOL.

1. I am requesting permission for the student named on the front of this form to possess and use an Epipen according to the doctor's verification on this form.
2. I will assume responsibility for safe delivery of the Epipen to school either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the Epipen.
4. **I will provide an additional Epipen to the clinic if my child is carrying an Epipen in accordance with the rules set by the Ohio legislature.**
5. I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent/Guardian

Date

The student has been instructed in the proper use of the Epipen Yes____ No ____

The student has demonstrated proper use of the Epipen Yes____ No ____

The Student is responsible to carry the Epipen with him/her Yes____ No ____

A NEW FORM MUST BE COMPLETED FOR EACH CHANGE AND EACH SCHOOL YEAR.

Physician Signature

Date

Physician printed name

Phone number

Medication	Dosage	Date	Time	Initials

Initials____ Signature____

Initials____ Signature____

Initials____ Signature____