# Eden Central Schools

Pupil Personnel Services
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## BEE STING ALLERGY

Student: _____ Grade: _____ DOB: _____

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

Unrestricted access to: ❑ Backpack ❑ Cell phone

School Contact: _____ Documentation: __**ON FILE** __**ATTACHED**

Mother: _____ Home #: _____ Work #: _____ Cell #: _____

Father: _____ Home #: _____ Work #: _____ Cell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

**SYMPTOMS OF AN ALLLERGIC 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 given immediately.**

Student Photo

**STAFF MEMBERS INSTRUCTED:** ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ 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

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