Place Student's Picture Here

Action Plan for Bee/Insect Sting Allergies

Name of Student: _____Grade:_____ School Year: _____
Program: _____ Date of Birth: _____

Dear Parent/Guardian:
It is indicated on your Emergency Medical Information that he/she has a bee or insect sting allergy. In order to provide the best medical care for your child, we request that you complete this form and return it to the nurse immediately.

1. **Symptoms student has experienced in the past: (Please check all that apply.)**

_____Swelling/redness of the sting area _____Hives
_____Swelling of lips, tongue, throat _____Hoarseness
_____Skin flushed all over the body _____Wheezing
_____Dizziness _____Breathing difficulty
_____Nausea _____Thickened speech
_____Vomiting _____Extreme weakness
_____Abdominal cramps _____Blue color of skin/lips
_____Itching all over the body _____Other:_____

2. **In the event of a sting, please provide the exact plan of care to be carried out:**
   Medications needed (list the order to be given)**
   1. Epinephrine: Inject into outer thigh ___ EpiPen 0.3 mg
   2. Antihistamine: Benadryl _____ mg to be given by mouth *only* if able to swallow

**If an EpiPen is listed above, I wish for it to be administered:
___Immediately after a bee sting regardless if symptoms of Anaphylaxis have presented
___Only IF signs/symptoms of Anaphylaxis are present

3. **My child has required an EpiPen in the past. (month and year) _____**
4. **Date of last bee sting (month and year) _____**
5. **My child no longer has a bee/insect sting allergy- please remove this from your information.**

Parent/Guardian AUTHORIZATIONS

_____ I want this allergy plan implemented for my child: I want my child to carry the EpiPen and agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of EpiPen.

_____ I want this plan implemented for my child and I do not want my child to self-administer EpiPen.

_____ It is recommended that backup medication be stored with the school and/or nurse in case a student forgets or loses EpiPen and/or antihistamine. The school district is not responsible or liable if backup medication is not provided to the school and/or nurse and student is without working medication when medication is needed.

I hereby give my permission for the medication(s) listed above to be given to my child by the nurse or the designee of the nurse. I relieve the Delaware Area Career Center School Board and its employees of liability in the administration of this medication.

Your signature gives permission for the nurse to contact and receive additional information from your healthcare provider regarding the allergic condition(s) and the prescribed medication.

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Student Agreement:

____ I have been trained in the use of my EpiPen and allergy medication and understand the signs and symptoms for which they are given;

____ I agree to carry my EpiPen with me at all times;
____ I will notify a responsible adult (teacher, nurse, administration, etc.) **IMMEDIATELY** when auto-injector EpiPen (epinephrine) is used;
____ I will not share my medication with other students or leave my EpiPen unattended;
____ I will not use my allergy medications for any other use than what it is prescribed for.

Student Signature: _____ Phone: _____ Date: _____

School Health Care Professional Authorization:

__This student has received instruction in the proper use of the EpiPen. It is my professional opinion that this student SHOULD be allowed to carry and use the EpiPen independently. The student knows when to request antihistamine and has been advised to inform a responsible adult if the EpiPen is self-administered.

___ It is my professional opinion that this student **SHOULD NOT** carry the EpiPen.
___ Back-up medication is stored at the school _____Yes _____ No

School Health Care Provider Signature_____Phone:_____Date:_____

Physician Authorization:

Physician's Name (Print) _____
Physician's Signature _____ Date _____