ACTION PLAN FOR BEE/INSECT STING ALLERGIES
BRIMFIELD CUST #309

Name of Student_____ Grade_____ School Year_____

Teacher_____

Dear Parent/Guardian,

It is indicated on your child's health record 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 School Nurse immediately.

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

___Swelling/redness of the sting area
___Swelling of the lips, tongue, throat
___Skin flushed all over the body
___Dizziness
___Nausea
___Vomiting
___Abdominal cramps
___Itching all over the body
___Hives
___Hoarseness
___Wheezing
___Breathing difficulty
___Thickened speech
___Extreme weakness
___Blue color of skin/lips
___Other:_____

2. **In the event of a sting, please provide the exact plan of care to be carried out: (If a prescription is needed, separate form for medication must be filled out by the physician.)**

Medication needed (list in order to be given)

Name and Dosage of Medication:_____
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Special Instuctions:
_____
_____

If an Epinephrine Autoinjector is listed above, I wish for it to be administered: (please circle)

- Immediately after a sting regardless if symptoms of Anaphylaxis are presented.
- Only IF signs/symptoms of Anaphylaxis are present.

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

I hereby give permission for the medication(s) listed above to be given to my child by the School Nurse or the trained designee of the nurse. I relieve Brimfield Grade School and its employees of liability in the administration of this medication. I agree to allow the school nurse to contact the prescribing physician concerning this medication if necessary.

Physian Name:_____ Physician Phone Number:_____

Physician Signature:_____ Date:_____

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Emergency Contact Information:

Parent/Guardian:_____ Phone:_____

Name/Relationship:_____ Phone:_____

Name/Relationship:_____ Phone:_____

Parent Signature:_____ Date:_____