SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS

EMERGENCY CARE PLAN: BEE STING ALLERGY

To be completed by Parent

Student______________________________Grade____Teacher/HR__________________DOB_____________

Asthmatic: ___yes* ___no *increased risk for severe reaction Insurance;____________________________

Mother's Name:________________________Home#______________Work#____________Cell____________

Father's Name_________________________Home#______________Work#____________Cell_____________

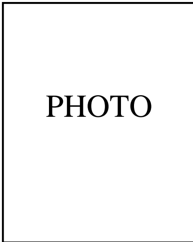
Emergency Contact:_____________________________Relationship_________________Phone____________

I give permission to share this plan with physician and school staff. I agree with the Health Care Provider's orders as outlined below:

Parent signature____Date______________________________

SYMPTOMS AND SIGNS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

(highlighted indicates previous response by the student)



- **MOUTH** itching & swelling of lips, tongue. or mouth
- **THROAT** itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- **SKIN** hives, itchy rash, and/or swelling about the face or extremities
- **GUT** nausea, abdominal cramps, and/or vomiting
- **LUNG** shortness of breath, repetitive coughing and/or wheezing
- **HEART** "THREADY" PULSE, "PASSING-OUT"

The severity of the symptoms can change quickly. It is important that treatment is given immediately.

To be completed by Health Care Provider

Allergens: (Please list)____

ACTION:

If **bee sting has occurred and/or the only symptom(s)** are:____

Give____**IMMEDIATELY.**

Medication(s)/dose/route

If **the following symptom(s)** develop:____,

Give____**IMMEDIATELY.**

Medication(s)/dose/route

I give permission for this student to **self-carry** and **self-administer** the above medication(s). **___Yes** **___No**

If so, she/he has been instructed in and understands the purpose and appropriate method and frequency of administration of the above medication(s).

Health Care Provider ______________________________________Phone___________________FAX______________

Printed name

Health Care Provider Signature____ Date___________________________

Information for Staff:

If bee sting or symptoms of an allergic reaction occur, follow plan, then contact school nurse at _________________ and parent immediately. Remove stinger if visible. Apply ice to area.

If **Epi-Pen/Epi-Pen Jr**. or **Twinject 0.3mg/Twinject 0.15mg** is administered, **call 911**. It provides a 20 minute response window. The student may experience an increased heart rate. This is normal. A staff member should accompany student to ER if the parent/emergency contact cannot be reached.

This plan is in effect for the current school year.

Please return to ___________________________________Phone #____________________FAX________________

IF EPI-PEN IS ADMINISTERED COMPLETE BACK OF FORM AND SEND TO ER WITH STUDENT. M3b/5-06

SCHOOL DISTRICT OF THE CITY OF NIAGARA FALLS

EMERGENCY CARE PLAN: BEE STING ALLERGY

STUDENT NAME____

Circumstances leading to administration of Epi-Pen____

____

____

____

____

____

CIRCLE ONE : **Epi-Pen / Epi-Pen Jr. , Twinject 0.3mg / Twinject 0.15mg given.**

DATE:_____________________ **TIME**__________________

RIGHT **LEFT**

LOCATION: Place an X on area where Epi-Pen or Twinject was administered.

____

SIGNATURE OF STAFF MEMBER WHO ADMINISTERED EPI-PEN/TWINJECT

SEND THIS FORM TO ER WITH STUDENT