# Valley Central School District
# Bee Sting Allergy Emergency Health Care Plan

Student Photo

Student: _____ Grade: _____ DOB: _____

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

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

**SYMPTOMS OF AN ALLLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:**
***The Severity of symptoms scan change quickly- it is important that treatment is given immediately***

**Mouth** Itching&swelling of lips, tongue or mouth
**Throat** Itching, thightness in throat, horse cough
**Skin** Hives, ichy rash, swelling of face and extremities
**Lungs** Shortness of breath, repetive cough,wheezing
**Heart** "Thready pulse, passing out"

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

**TO BE COMPLETED BY THE PHYSICIAN OF HEALTH CARE PROVIDER**

**TREATMENT:** Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms
**Medication ordered:** _____ Dose: _____ Route: _____ Frequency: _____

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**Special instructions:** _____
**Call school nurse.** Call parent/guardian if off school grounds.

**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.**
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.

Written by: _____ Date: _____

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

**Health Care Provider Signature:** _____ Date: _____

Please Stamp

*This plan is in effect for the current school year and summer school as needed.*

Revised 5/09

**Valley Central School District**

## PROVIDER AND PARENT PERMISSIONS
## REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

**Directions for the Health Care Provider:** This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A provider **order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

**Student Name:** _____ **DOB:** _____

**Health Care Provider Permission for Independent Use and Carry**

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

**Parent/Guardian Permission for Independent Use and Carry**

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: _____ Date: _____

**Please return to School Nurse:**

| | | |
|---|---|---|
| School Nurse: | | School: |
| Phone #: | Fax: | Email: |