

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 ALLERGIC 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, itchy rash, swelling of face and extremities
Lungs Shortness of breath, repeteive 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. Rins 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.

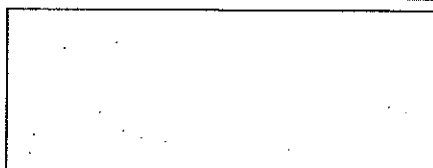
Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room 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



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
- _____ which requires rapid administration of _____
(State Diagnosis) (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: