DISTRICT ADMINISTRATION OFFICE
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EMERGENCY PROCEDURE FOR BEE/WASPS STINGS

School Year: ___________________________

Student's Name: ____ School: _______________

Date of Birth: __________________________ Gender: _________________ Grade: _____________________

Parent/Guardian's Name: ____

Mailing Address: ____

Home Phone: _____________________________________ Work Number: _______________________________

Cell Phone: ____

Physician: ____________________________Physician's Number: __________________ Fax:_______________

Allergies to: ____

Which insect(s) is your child allergic too? ____

What symptoms does your child experience when stung? *(Check all that apply)*

_____ Tightness in throat
_____ Tightness in chest
_____ Burning rash/hives
_____ Severe itching
_____ Sweating
_____ Ashy, grayish skin color
_____ Coughing
_____ Swollen face, mouth, tongue
_____ Severe difficulty breathing
_____ Flushing of skin
_____ Dizziness
_____ Nausea/vomiting
_____ Loss of consciousness
_____ Convulsions

Other symptoms (list) ____
____

Medications:

Epi-Pen Yes or No *(circle one)* Dose: ___________ mg Subcutaneous
Can your child administer own Epi-Pen? Yes or No *(circle one)*

Benadryl Yes or No *(circle one)* Dose: ___________ mg By mouth

What measures are taken at home when your child is stung?
____
____
____

If a student has a known allergy and has an Epi-Pen available, inject immediately by following the instructions on the Epi-Pen. (Staff trained in the use of the Epi-Pen will administer.)

Call 911 with any of the above symptoms – DO NOT LEAVE CHILD ALONE.

Give Benadryl _______________ mg as instructed in Care Plan and on the Request to Administer Medication form.

Contact parent/guardian and notify of sting and what has been done for child.

Remove any embedded stinger with a credit card or similar object. Wash area with soap and water. Apply cold/ice pack to area that was stung.

Keep student warm and avoid exertion.

Monitor student for any further signs of allergic reaction for at least twenty (20) minutes following a sting-this applies to any student, including those without a history of allergic reaction to bee stings.

This information may be shared with all appropriate staff

____ _______________________________

Student's Signature Date

____ _______________________________

Parent/Guardian's Signature Date

____ _______________________________

Health Care Provider's Signature Date

CARE PLAN REVIEWED WITH SCHOOL PERSONNEL

School Representative Signature(s)	Date