EMERGENCY PLAN – BEE STING

Confidential

Student's Name___________________________Grade_____School___________ Year_______

Parent/Guardian_______________________Phone # Work____________Home #___________

Physician____Phone #____________________

Family member/Friend, who is aware of child's condition.
Name____Phone#_____________________

Please tell us what you would want us to do in case of a BEE STING REACTION at school.
(Please check all that apply)

Name of Medication to be given:________________________ When/if: ____________________

Symptoms: **Give Checked:**

Symptoms	Give Checked
If stung by bee, wasp, bug, but NO symptoms:	use ☐ Epinephrine ☐ Antihistamine
Mouth: itching, tingling or swelling of lips, tongue, mouth:	use ☐ Epinephrine ☐ Antihistamine
Skin: hives, itchy rash, swelling of the face or extremities:	use ☐ Epinephrine ☐ Antihistamine
Gut: nausea, abdominal cramps, vomiting, diarrhea:	use ☐ Epinephrine ☐ Antihistamine
***Throat:** Tightening of throat, hoarseness, hacking cough:	use ☐ Epinephrine ☐ Antihistamine
***Lung:** Shortness of breath, repetitive coughing, wheezing:	use ☐ Epinephrine ☐ Antihistamine
***Heart**: Fainting, pale, blueness, weak or thready pulse, low blood pressure:	use ☐ Epinephrine ☐ Antihistamine
***other**: ____	use ☐ Epinephrine ☐ Antihistamine
If reaction is progressing (several of the above areas affected)	use ☐ Epinephrine ☐ Antihistamine

***Potentially life-threatening. The severity of symptoms can quickly change.**

☐ Notify parent by: ☐ Send note home ☐ Call parent by phone
☐ Allow to rest for _____________ minutes.
☐ Call 911 if: ____
☐ Other/Comments: ____

Date of last BEE STING REACTION :______________
Reaction at that time: ____

If medication is needed, a supply must be kept at school for your child to participate in field trips/extracurricular activities. If your child rides the bus, it is recommended that you provide either the Epi-Pen or one dose of your child's oral medication to the transportation department. School district medication policy and procedures will apply.

- ☐ Yes, my child requires medication on the bus. (Please provide the medication to the transportation department supervisor).
- ☐ No, my child does not require medication on the bus.

Parent Signature_____________________________________ Date______________

School Nurse Signature _______________________________ Date of review_________

Physician Signature __________________________________ Date ________________

Upon completing this form, please print the form and hand it in at registration OR save it and email the form to Susan Resch, RN, BSN at sresch@newlondon.k12.wi.us. If medication is needed for this concern, you must also fill out a medication consent form. Thank you.