

SCHOOL DISTRICT OF NEW LONDON - HEALTH SERVICES

Emergency Action Plan – BEE STING

Confidential

Student's Name _____ Grade _____ School _____ Year _____

Parent/Guardian _____ Phone # Work _____ Home # _____

Physician _____ Phone # _____ Fax # _____

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:

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

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

**Emergency medication will be sent with school staff on all school sponsored field trips.

Yes, my child requires medication on the bus to and from school.
(Please provide the medication to the transportation department supervisor).

No, my child does not require medication on the bus to and from school.

Parent Signature _____ Date _____

School Nurse Signature _____ Date of review _____

Physician Signature _____ Date _____