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 ☐ 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: θ Send note home θ 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.

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

θ **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 _____

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