**Penn Cambria School District**

**Bee Sting Emergency Care Plan**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_ HR: \_\_\_\_\_\_

The following is standard school district procedure for anyone stung by a bee or insect:

1. Remove the stinger if visible.
2. Apply sting kill swab.
3. Apply ice pack.
4. Observe the student closely for 10-15mins for a reaction.

Please check the status of your child’s reaction to bee stings or insect bites below:

\_\_\_\_\_ My child has localized reaction (swelling or redness at the site of sting)

\_\_\_\_\_ My child has a severe reaction (difficulty breathing, generalized swelling,

redness, numbness, hives or itching)

Describe your child’s reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your child has a severe reaction has he/she:

\_\_\_\_\_Begun desensitization treatment (allergy shots)

\_\_\_\_\_ Begun maintenance dose of desensitization treatment

\_\_\_\_\_ My child has not been desensitized

If your child has a reaction to bee stings or insect bites please check the procedure to follow:

\_\_\_\_\_ Follow routine school district policy

\_\_\_\_\_ Notify parent at once

\_\_\_\_\_ Give medication prescribed by my child’s healthcare provider.

**The back of form must be completed with signature from your child’s healthcare provider for Epinephrine.**

**\_\_\_\_\_ Epinephrine is to be given immediately or**

**\_\_\_\_\_ Benadryl should be given first and then watch student for need of**

**Epinephrine.**

**\_\_\_\_\_** Call 911 immediately.

\_\_\_\_\_ Call 911 if necessary.

May we give your child Benadryl for localized reaction? \_\_\_\_\_Yes \_\_\_\_\_ No

Parents, please make your child aware of his/her bee sting allergy and of the need to inform someone of having been stung by a bee/insect.

Parent’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Penn Cambria School District**

**Medication Administration Consent & Licensed Prescriber Order**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_ HR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving the medication at school, **each student** must provide the school nurse with a ***Medication Administration Consent***form signed by the student‘s parent/guardian and a ***Medication Order***from a licensed prescriber. **All medications must be in an** **original prescription bottle/container from a pharmacy** **and brought into school by a parent/guardian when possible. This order applies to all over-the-counter medications as well as prescriptions.**

**Licensed Prescriber Medication Order:**

**Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Route and dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of administration: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Directions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Discontinuation Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student may carry and self- administer epinephrine? \_\_\_\_\_ Yes \_\_\_\_\_ No**

**(\* Student & Parent please complete back of paper)**

**Licensed Prescriber signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Licensed Prescriber name printed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**………………………………………………**

**Parent/Guardian Consent:**

I give my permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to receive the following medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school health personnel according to my child‘s licensed prescriber‘s directions.

Parent/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian name printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_