Bee Sting Allergy Action Plan

Place Child's Picture Here

ALLERGY TO:_____

Student's Name:_____ D.O.B:_____ Teacher:_____

Asthmatic Yes* ☐ No ☐ *High risk for severe reaction

◆ SIGNS OF AN ALLERGIC REACTION ◆

Systems:	Symptoms:
•MOUTH	itching & swelling of the lips, tongue, or mouth
•THROAT*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
•SKIN	hives, itchy rash, and/or swelling about the face or extremities
•GUT	nausea, abdominal cramps, vomiting, and/or diarrhea
•LUNG*	shortness of breath, repetitive coughing, and/or wheezing
•HEART*	"thready" pulse, "passing-out"

The severity of symptoms can quickly change. *All above symptoms can potentially progress to a life-threatening situation.

◆ ACTION FOR MINOR REACTION ◆

1. **If only symptom(s) are:**_____, give_____
medication/dose/route
_____

Then call:

2. Mother_____, Father _____, or emergency contacts.
3. Dr. _____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

◆ ACTION FOR MAJOR REACTION ◆

1. **If ingestion is suspected and/or symptom(s) are:**_____,

give_____IMMEDIATELY!
medication/dose/route

Then call:

2. Rescue Squad (ask for advanced life support)
3. Mother_____, Father _____, or emergency contacts.
4. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature_____Date_____ Doctor's Signature_____ Date____

Compass Academy CHARTER SCHOOL

"Where all children will learn, lead and become the future."

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WHENEVER POSSIBLE, PARENTS ARE ADVISED TO GIVE MEDICATION AT HOME AND ON A SCHEDULE OTHER THAN SCHOOL HOURS. IF IT IS NECESSARY THAT A MEDICATION BE GIVEN DURING SCHOOL HOURS, THESE INSTRUCTIONS MUST BE FOLLOWED:

1. Medication must be brought in the School Nurse's Office, by an adult, at the beginning of the school day.
2. Medication to be given must be brought to school in the original container, with appropriate label intact.
3. Permission to dispense medication must be completed by prescribing physician/dentist.
4. Permission to administer medication must be by parent/guardian.

TO BE COMPLETED BY FAMILY PHYSICIAN/PRACTITIONER: (Please return to school nurse)

NAME _____ SEX____ BIRTHDATE____/___/____

PARENT OR GUARDIAN_____ HOME PHONE_____

HOME ADDRESS_____

SCHOOL_____ GRADE_____ TEACHER/HOMEROOM_____

In order to provide an appropriate educational program the following medication must be provided during the school day:

DIAGNOSIS_____

Medication	Route	Dose	Time	Nurse	Self	Assist

During a field trip:

In the event that the school nurse or a substitute cannot be sent on the trip, a student may not receive medication while on the field trip. If advisable, please give the school nurse directions on how to alter the student's medication regime for a field trip.

_____ The nurse may skip the medication during the school day, in the case of a field trip

_____ The medication may be given on an alternate schedule, for the day of the field trip.
The altered field day schedule is:_____.

_____ The student may self-administer asthma inhaler under supervision.

_____ _____
SIGNATURE OF PHYSICIAN OR DENTIST **DATE SIGNED**

_____ _____
PRINTED NAME OF PHYSICIAN OR DENTIST **OFFICE PHONE NUMBER**

TO BE COMPLETED BY PARENT/GUARDIAN:

The nursing staff has my permission to administer the above medication(s) to my child, as prescribed, during school and on field trips. I understand that all medication must be in the original container with appropriate label intact, and must be brought by an adult to the School Nurse's Office. The School Health Staff has my permission to contact my child's provider(s) for information or records as needed to care for my child.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE SIGNED**

In the effort to avoid possible drug interactions, please list additional medications given at home.
Medication_____ **Dose**_____ **Time**_____

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