Insect Sting Allergy Action Plan

Student Name ______________________________ Date of Birth ________ Grade ___ School Year ______

Allergy To:

____

____

Asthmatic: __ Yes __No

TREATMENT (To be completed by physician) A medication form must be filled out for each medication		
SYMPTOMS:	**GIVE CIRCLED MEDICATION (TO BE COMPLETED BY A PHYSICIAN)**	
If a sting has occurred, but NO SYMPTOMS	EpiPen	Antihistamine
MOUTH: Itching, tingling, or swelling of lips, tongue	EpiPen	Antihistamine
SKIN: Hives, rash, swelling of face or extremities	EpiPen	Antihistamine
GUT: Nausea, cramping, vomiting, diarrhea	EpiPen	Antihistamine
THROAT* : Tightening of throat, hoarseness, cough	EpiPen	Antihistamine
LUNG* : Shortness of breath, cooughing, wheezing	EpiPen	Antihistamine
HEART* : Thready pulse, low blood pressure, fainting	EpiPen	Antihistamine
OTHER:	EpiPen	Antihistamine
If reaction is progressing or several of the above areas are affected	EpiPen	Antihistamine
Potentially life-threatening. 9-1-1 WILL BE CALLED IF EPIPEN IS ADMINISTERED		
Epinephrine (circle): EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg Auvi-Q 0.15 mg Auvi-Q 0.3 mg		
Antihistamine (Name/Dose/Route):		

EMERGENCY CONTACTS

Name/Relationship to Student	**Phone number(s)**
1	1. 2.
2	1. 2.
3	1. 2.
Physician	

I give permission for school personned to follow this plan and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and corresponding forms. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature	Date
Physician's Signature	Date
Nurse's Signature	Date

To the Parent/Guardian:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT WHO POSSESSES AND USES PRESCRIBED EPIPENS IN SCHOOL.

1. I am requesting permission for the student named on the front of this form to possess and use and Epipen according to the doctor's verification on this form.
2. I will assume responsibility for safe delivery of the Epipen to school either by myself or by the student.
3. I will notify the school immediately if there is any change in the use of the Epipen.
4. **I will provide an additional Epipen to the clinic if my child is carrying an Epipen in accordance with the rules set by the Ohio legislature.**
5. I release and agree to hold the Board of Education, its officials, and its employees, harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

____ ________________________________

Signature of Parent/Guardian Date

The student has been instructed in the proper use of the Epipen Yes____ No _____

The student has demonstrated proper use of the Epipen Yes____ No_____

The Student is responsible to carry the Epipen with him/her Yes____ No____

A NEW FORM MUST BE COMPLETED FOR EACH CHANGE AND EACH SCHOOL YEAR.

____ _________________

Physician Signature Date

_______________________________________ ____________________________

Physician printed name Phone number

Medication	Dosage	Date	Time	Initials

Initials_____ Signature____

Initials_____ Signature____

Initials_____ Signature____