WARWICK SCHOOL DISTRICT

BEE STING / INSECT BITE ALLERGY EMERGENCY CARE PLAN

Name of Student: _____ Grade/Teacher: _____

Attention Parent/Guardian:

You have identified your child as having an allergy or localized reaction to bee stings and/ or insect bites. Please make sure that your child is aware of his/ her allergy or reaction and the need to inform an adult if a bee sting or insect bite occurs. Check the status of your child's reaction to bee stings and/ or insect bites below and return this information sheet to the school nurse **immediately.**

( ) My child is **allergic to bee stings.** He/ she develops difficulty breathing, generalized swelling, numbness, and/ or hives. Other symptoms: _____.

( ) My child is **allergic to insect bites**. He/she develops difficulty breathing, generalized swelling, numbness, and/ or hives. Other symptoms: _____.

( ) My child develops a **localized reaction to a bee sting** (swelling or redness at the site of the sting).

( ) My child develops a **localized reaction to an insect bite** (swelling or redness at the site of the bite).

( ) My child receives desensitization treatments (allergy shots) to reduce his/her allergic reaction.

The following is **standard school procedure** for treatment of **any** bee sting or insect bite:

1. Remove the stinger if visible.
2. Apply a sting kill swab (topical anesthetic).
3. Apply ice.
4. Observe the student closely for 20 minutes and return to class if no signs of allergic reaction develop.
5. Notify the parent.

If your child has a bee sting or insect bite during school, please check the following procedure(s) you would like the school nurse to follow:

( ) Follow the standard school procedure as described above.

( ) Give Benadryl orally to my child, 12.5 mg to 50 mg, as per the standing medication order from the school physician.

( ) Give medication as prescribed by my child's physician. Parents must provide the medications with the **written orders** from the child's physician **each** school year. **NOTE:** Parents who request that the student self-carry his or her Epinephrine Auto-Injector must complete the Epinephrine Auto-Injector Self Administration Authorization Form **each** school year.

( ) Call 911 and have my child transported by ambulance to the hospital if signs of a severe allergic reaction develop. **NOTE: School policy requires that 911 be called if epinephrine is given.**

( ) Call Mother _____ (Phone #) Father _____ (Phone #) Emergency Contact _____ (Phone #)

( ) Call physician, Dr. _____ at phone number: _____.

( ) Other Instructions: _____.

Note: **You are encouraged to alert all other school and after-school personnel (transportation, cafeteria, coaches, etc.) who may have contact with your child, so that they are aware of your child's diagnosis and treatment that may be needed.**

Parent Signature:_____ Date: _____

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