ANAPHYLAXIS PLAN
BEE STING ALLERGY

STUDENT: ______________________________ GRADE: ________ DOB: __________

ASTHMATIC: □NO □YES (Higher risk for severe reaction) INHALER: □CLINIC □CARRIES

HEALTHCARE PROVIDER: __________________________ PHONE: _________________

PREFERRED HOSPITAL: ____

EMERGENCY CONTACT: ______________________ RELATIONSHIP: ________ PHONE: _________

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TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

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SYMPTOMS: Please Check the Symptoms That May Apply To This Child

Mouth □Itching □Tingling Swelling of: □Lips □Tongue □Mouth
Skin □Hives □Itchy Rash □Swelling of the face or extremities
Gut □Nausea □Abdominal Cramps □Vomiting
Throat╪ □Tightening of Throat □Hoarseness □Hacking Cough
Lung╪ □Shortness of Breath □Repetitive Coughing □Wheezing
Heart╪ □Weak or thready pulse □Low Blood Pressure □Fainting □Pale skin □Blue hue to skin
Other╪ ____
(╪Potentially life-threatening)

TREATMENT to be given: □with symptoms □without waiting for symptoms

Give both EPIPEN and Antihistamine simultaneously □YES □NO
Special Instructions: ____

EPINEPHRINE: □0.3MG □0.15MG EXPIRATION DATE ________ □CLINIC □CARRY
□ Administer 2nd dose if symptoms do not improve in 15-20 minutes
ANTIHISTAMINE: _______ CC/MG ____

ASTHMA RESCUE (IF ASTHMATIC) TO BE ADMINISTERED: ____________________

***PARENT/GUARDIAN MUST PROVIDE 2 EPINEPHRINE INJECTORS WHICH WILL NOT EXPIRE DURING THE CURRENT SCHOOL YEAR (SELF/CLINIC)

Student has been instructed and is capable of self-administering own medication □YES □NO
Student is able to recognize signs and symptoms of reaction □YES □NO
Student knows how to access emergency help in the school setting □YES □NO

COMPLETE BOTH SIDES

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Part 2

- I request this medication be administered as ordered by the student's licensed health care provider.
- I give Joseph Badger School's staff permission to communicate with the health care provider about this medication.
- I understand that these medications may be administered by certified staff members who have been trained in the administration of emergency medication.
- I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. **Expired medication cannot be administered.**
- Medication must be in the original prescription container with instructions as noted by above health care provider.
- I will provide an additional EPIPEN in the clinic if my child is authorized to self-carry.
- In the event of an emergency, I give my permission for transport and treatment at the nearest medical facility.

Healthcare provider Signature: ____________________________ Phone: _________ Date: _____

Parent/Guardian Signature: _______________________________ Date: __________ □Copy for parent

FOR SCHOOL CLINIC USE ONLY:

LOCATIONS WHERE EPIPEN/MEDICATIONS ARE STORED:

□ Clinic □ Backpack □ Bus #___ □ Coach □ Other _______________________

TRANSPORTATION PLAN: Bus driver notified of student's allergy Date ______

- This student MUST carry EPIPEN on bus □YES □NO
- EPIPEN can be found in □Backpack □On person □Other________
- Student required preferential seating on bus □YES □NO

STAFF MEMBERS TRAINED ON EPIPEN USE/ADMINISTRATION:

- Staff Signature/date____________________________________
- Staff Signature/date____________________________________
- Staff Signature/date____________________________________
- Staff Signature/date____________________________________