Little Chute Area School District

Health Services

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Student's Name:	**DOB:**	**Date:**
School Attending:	**Grade:**	**Bus Student:** Yes No

Health Condition: **Bee Sting Allergy (Known) – Emergency Care**

Symptoms of student's allergic reaction (check all that apply):

- ❑ Hives, itchy rash, swelling of face or extremities
- ❑ Swelling at site (describes) _____
- ❑ Severe pain at site of sting
- ❑ Itching, tingling or swelling of lips, tongue, mouth
- ❑ Red, itchy, watery eyes
- ❑ shortness of breath, repetitive coughing, wheezing
- ❑ Other (describe) _____

EMERGENCY PROCEDURE:

1. Give appropriate medication as listed below.
2. **If Epipen given, call 911**: State that an allergic reaction has been treated.
3. Additional epinephrine may be needed. If symptoms continue, repeat epi-injector after 5-10 minutes.
4. Stay with student and monitor.
5. If self-administered, student must notify school personnel.

EMERGENCY CONTACT: Name: Phone: Relationship to student:

FOR COMPLETION BY PHYSICIAN: **Physician's Name:** **Phone:**

Epinephrine: Inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Auvi-Q™ 0.3 mg Auvi-Q™ 0.15 mg

Antihistamine: give: medication/dose/route _____

Other: give: medication/dose/route _____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Is the child knowledgeable about his or her medication & need to notify school personnel if epinephrine is administered: Yes _____ No _____

Has the child demonstrated the proper technique in administering medication: Yes _____ No _____

Side effects:

( ) I have instructed _____ in the proper way to use his/her injected medications. It is my professional opinion that he/she should be allowed to carry and use this injected medication by him/herself.

( ) It is my professional opinion that _____ should not carry and use his/her injected medication by him/herself.

Physician's Signature:	**Date:**

FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer Epinephrine: Yes _____ No _____

Medication Consent: I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

If self-administration is allowed, or if no authorized staff member is available, I ask that my child be permitted self-medication as authorized by my physician and myself.

I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. .

Students health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing you agree you have reviewed this health plan for your child and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parent Signature:	**Date:**