Little Chute Area School District
Health Services
BEE & INSECT ALLERGY

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STUDENT INFORMATION

STUDENTS NAME:	**DOB**:	**GRADE:**
SCHOOL ATTENDING:	**BUS STUDENT**: *YES* *NO*	
LIST ALL INSECTS YOUR CHILD IS ALLERGIC TO:		
ASTHMA HISTORY: *YES* *NO*	***Note: A history of asthma increases the risk of anaphylaxis.***	
HISTORY OF ANAPHYLAXIS/ALLERGIC REACTION: *YES* *NO*		
If yes, describe signs and symptoms during reaction: _____		
Has epinephrine ever been administered? *YES* *NO* *If **yes**, when?*		

SEVERE ALLERGY & ANAPHYLAXIS TREATMENT

REACTIONS TO WATCH	*STEPS TO TAKE TO REACTIONS*
SEVERE ALLERGY & ANAPHYLAXIS: *If a child has ANY of these severe symptoms after eating food or having a sting, give Epinephrine.* ● Shortness of breath, wheezing, or coughing ● Skin color is pale or has a bluish color ● Weak pulse ● Fainting or dizziness ● Tight or hoarse throat ● Trouble breathing or swallowing ● Swelling of lips or tongue that bothers breathing ● Vomiting or diarrhea (if severe) ● Many hives or redness over the body ● A feeling of "doom", confusion, altered consciousness, or agitation	**SEVERE ALLERGY & ANAPHYLAXIS (*OR SPECIAL SITUATION IS MARKED*) STEPS:** 1. Inject epinephrine right away! Note the time it was given 2. Call 9-1-1. ○ Ask for an ambulance with epinephrine ○ Tell rescue squad when epinephrine was given 3. Stay with the child and: ○ Call parents ○ Give second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes ○ Keep child lying on back. If child vomits or has trouble breathing, move child to lie on side 4. Give other medication, if prescribed. Do not use other medicine in place of epinephrine ○ Antihistamine ○ Inhaler/ bronchodilator
MILD ALLERGIC REACTIONS: *If a child has had any mild symptoms, monitor the child. Symptoms may include:* ● Itchy nose, sneezing, itchy mouth ● A few hives ● Mild stomach nausea or discomfort	**MILD ALLERGIC REACTIONS STEPS:** *Stay with the child and:* 1. Watch child closely 2. Give antihistamine (if prescribed) 3. Call parents 4. If more than 1 symptom of severe allergy/anaphylaxis develops, give Epinephrine. (See "Severe Allergy & Anaphylaxis")

***SPECIAL SITUATION*:**

	Check the left box if the child has an **extremely severe allergy** to an insect or these food(s): _____. *Even if the child has **MILD** symptoms after a sting or eating the above foods, give Epinephrine.*

MEDICATION & AUTHORIZATION

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:

CHILD MAY SELF-CARRY: *YES* *NO* *If **no**, location of Epinephrine:*

PARENT/GUARDIAN 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 medication(s) 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.

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

EMERGENCY CONTACT:	**RELATIONSHIP TO STUDENT:**
(H) PHONE:	**(C) PHONE:**

PARENT/GUARDIAN SIGNATURE:	**DATE:**
PHYSICIANS NAME:	**PHONE:**
PHYSICIANS SIGNATURE:	**DATE:**

Principal's Initials: _____ Date: _____