Rev. 06-2010

NSG-202A

"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS
6579 Royalton Road
North Royalton, Ohio 44133

Bee/Wasp/Hornet Sting Allergy

Dear Parent/Guardian,

You have indicated that your child has a severe allergy to bee/wasp/hornet stings. A severe allergy is classified as requiring the need of medication (EpiPen/Benadryl) in the event of a sting. Please complete the attached **BEE STING ALLERGY PLAN** and **ADMINISTRATION OF MEDICATION REQUEST** if your child has a severe allergy and return it as soon as possible to the school's clinic. The information will only be shared with the appropriate personnel such as your child's classroom teacher(s) and physical education teacher. This information that you provide will help to ensure the health and safety of your child.

Students are permitted to carry and administer their own EpiPen provided that the physician AND parent authorize the student to do so on the Administration of Medication Request form. We do request, however, that a spare EpiPen be kept in the school clinic should your child not have his or hers. Benadryl must be kept in the school clinic.

If your child:

- No longer has an allergy to a bee sting, please handwrite a note and forward it to the school clinic as soon as possible so that we may remove his/her name from our list.

Or

- Does not require medication to treat the allergy, please handwrite a note regarding this special circumstance including the treatment that should be provided and forward it to the school clinic as soon as possible.

Please continue to inform the school's nurse of any changes in your child's health condition should a change arise.

Thank you,

Michele L. Prezenkowski RN BSN
District Health Coordinator
North Royalton City Schools
14709 Ridge Road
North Royalton, Ohio 44133
440.582.9067

Rev. 06-2010

NSG-202B

"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS
BEE STING ALLERGY PLAN
* CONFIDENTIAL*

☐ Addendum Attached

_____ _____

Received by Date

Student's Name	Student's Date of Birth	Grade
Allergy to:		School Year

Asthmatic: YES* ☐ or NO ☐ (Please check one) *Higher risk for severe reaction

Child's Picture

STEP 1: TREATMENT (To be completed by physician)

SYMPTOMS:	GIVE CIRCLED MEDICATION: (TO BE DETERMINED BY PHYSICIAN)	
If a food allergen has been ingested, 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, coughing, 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, give:	EpiPen	Antihistamine

Potentially life-threatening. 911 WILL BE CALLED IF EPIPEN IS ADMINISTERED

MEDICATION:

Epinephrine (circle): **EpiPen** **EpiPen Jr.** **Twinject 0.3mg** **Twinject 0.15mg**

Antihistamine:_____

(Name/Dose/Route)

Other:_____

(Name/Dose/Route)

STEP 2: EMERGENCY CALLS

1. Call 911 and state that an allergic reaction has been treated with:_____

(Name of Drug)

2. Call Parent/Guardians:

Name/Relationship	Phone Number(s)	
a.	1.	2.
b.	1.	2.
c.	1.	2.

3. Notify Dr._____ **at** _____

(Name) **(Phone Number)**

I GIVE PERMISSION FOR SCHOOL PERSONNEL TO FOLLOW THIS PLAN, ADMINISTER MEDICATION (IF ANY) AND CARE FOR MY CHILD AND CONTACT MY PHYSICIAN IF NECESSARY. I ASSUME FULL RESPONSIBILITY FOR PROVIDING THE SCHOOL WITH PRESCRIBED MEDICATION AND DELIVERY/MONITORING DEVICES. I APPROVE THIS BEE STING ALLERGY PLAN FOR MY CHILD. 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(s) Signature	Date
Physician's Signature	**Date**

Trained Staff Members/Information Forwarded To/EpiPen® and EpiPen Jr® Instructions

TRAINED STAFF MEMBERS (TO BE COMPLETED BY SCHOOL OFFICIALS)	
NAME	**LOCATION**
1.	
2.	
3.	

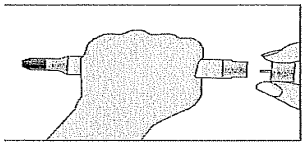
THE EMERGENCY ALLERGY PLAN HAS BEEN FORWARDED TO THE FOLLOWING INDIVIDUALS/DEPTS.		
☐ Dietary	☐ Transportation	☐ Building Administration
☐ Teaching Staff	☐ Office Staff	☐ Other

anaphylaxis Guidelines for schools

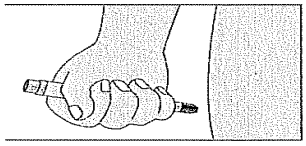
EpiPen® and EpiPen Jr® instructions

An EpiPen is an auto injector designed for lay use.

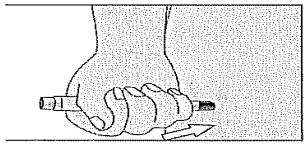
1. Remove from plastic container.
2. Form fist around EpiPen and pull off grey cap.



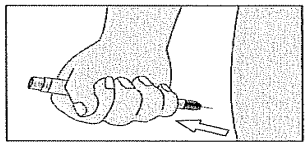
3. Place black end against outer mid-thigh.



4. Push down hard until a click is heard or felt and hold in place for 10 seconds.



5. Remove EpiPen and be careful not to touch the needle. Massage the injection site for 10 seconds.



*Note: If the student becomes unconscious, stops breathing or there is no pulse apply immediate emergency care procedures (**D**anger, **R**esponse, **A**irway, **B**reathing, **C**irculation).*