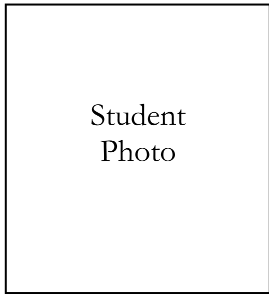
Valley Central School District
Bee Sting Allergy Emergency Health Care Plan



Student: ______________________________ Grade: ______ DOB: _________

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Severity of reaction(s): ________________

Mother: ______________________ MHome #: _________ MWork #: __________ MCell #: __________

Father: ______________________ FHome #: _________ FWork #: __________ FCell #: __________

Emergency Contact: ____________________ Relationship: ____________ Phone: ______________

SYMPTOMS OF AN ALLLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:
The Severity of symptoms scan change quickly- it is important that treatment is given immediately

Mouth Itching&swelling of lips, tongue or mouth
Throat Itching, thightness in throat, horse cough
Skin Hives, ichy rash, swelling of face and extremities
Lungs Shortness of breath, repetive cough,wheezing
Heart "Thready pulse, passing out"

STAFF MEMBERS INSTRUCTED:
❑ Classroom Teacher(s)
❑ Administration
❑ Support Staff
❑ Special Area Teacher(s)

TO BE COMPLETED BY THE PHYSICIAN OF HEALTH CARE PROVIDER

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms

Medication ordered: ______________ Dose: ____________ Route: ___________ Frequency: ________

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Special instructions: ____

Call school nurse. Call parent/guardian if off school grounds.

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Written by: ____________________________________ Date: ____________________

Parent/Guardian Signature to share this plan with Provider and School Staff: ____________________

Health Care Provider Signature:______________________________ Date: ________________

Please Stamp

This plan is in effect for the current school year and summer school as needed. Revised 5/09