OCONOMOWOC AREA SCHOOL DISTRICT

EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

Bee/Insect Allergic Reaction Health Care Plan

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Name	_____	School Year	_____
Birthdate	_____	School	_____
Practitioner	_____	Grade	_____
Practitioner Phone		Practitioner Fax	

☐ **Bee/Insect Reaction symptoms are no longer an issue for my child. (Please sign and return Care Plan)**

LOCAL REACTIONS TO BEE/INSECT BITE OR STING

A local reaction is defined as redness, swelling and itchiness at site of bite or sting.

- Wash area with soap and water.
- Give Oral: Antihistamine: - Medication Name:_____ Dose:_____
- Observe student for at least 15 minutes for more severe reaction.
- If a severe reaction occurs, follow guidelines below "for severe allergic reaction".

SEVERE ALLERGIC REACTION – REQUIRES MEDICAL ATTENTION IMMEDIATELY

The symptoms may be any or all of the following:

- ☐ Itching and swelling of the lips, tongue or mouth.
- ☐ Itching and/or a sense of tightness in the throat, hoarseness and hacking cough
- ☐ Hives, itchy rash, and/or swelling about the face or extremities
- ☐ Nausea, abdominal cramps, vomiting and/or diarrhea
- ☐ Shortness of breath, repetitive coughing and/or wheezing
- ☐ "Thready" pulse, "passing out"

****The severity of symptoms can quickly change and progress to a life-threatening situation****

☐ Give Antihistamine: - Medication Name:_____ Dose:_____

☐ Give injection of:

☐ No Epinephrine ☐ Epinephrine Dose: ☐ 0.3 mg ☐ 0.15 mg

☒ Per State Statute, 911 will be called any time Epinephrine is administered.

******Please supply the school with the needed medication(s) on or prior to the first day of school******

☐ It is my professional opinion that this student **should** be allowed to carry the Epi-pen medication

Where will the Epi-pen be kept:_____

☐ It is my professional opinion that this student **should not** carry his/her Epi-pen medication.

_____

Practitioner Signature **Date**

How should medication be returned home the last week of school? ☐Sent home with Student ☐Parent/Guardian Pick-Up

- I hereby give permission to OASD's trained staff to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's practitioner with any concerns regarding medication administration. I agree to hold the Oconomowoc Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- I allow the named practitioner (office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.
- I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

_____

Parent/Guardian Signature **Date**