

Tussey Mountain School District

Bee Sting Procedure

Student's Name: _____ Date of Birth: _____

Grade: _____ Home Room Teacher: _____

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

- ☐ Hives, itchy rash, swelling of face or extremities
- ☐ Swelling at site (describe) _____
- ☐ 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) _____

Does your child have a physician order for Epinephrine at school? _____ Yes _____ No

◆ ROUTINE BEE-STING PROCEDURE FOR ALL STUDENTS◆

- Check Student Health Concern list to see if student is allergic to stings. If allergic, follow emergency procedure listed below.
- If stinger is present, scrape it off with stiff paper or card. Do not squeeze to remove.
- Clean area with soap and water.
- Apply ice to the sting area or other antiseptic/ anti-sting swabs.
- Observe student in office for 10-15 minutes for allergic reaction.
- If no reaction is present after observation time, student may return to class. Classroom teacher should be notified that student was stung as delayed reactions are possible.

◆ EMERGENCY PROCEDURE FOR ALLERGIC STUDENTS ◆

Please check the appropriate treatment for your child should he/she be stung at school:

- ☐ Use the above Routine Bee-Sting Procedure ONLY
- ☐ Use the above Routine Bee-Sting Procedure, but ALSO give Benadryl. The school keeps Diphenhydramine (generic Benadryl) chewable tablets (12.5mg each) on hand for emergency use only. ** Age appropriate dose will be given as advised by the school doctor unless you provide specific dosage instructions from your child's doctor. **
- ☐ Use the above Routine Bee-Sting Procedure, but ALSO administer Epinephrine as ordered by physician. Medication permission form for Epi-Pen must be on file at school. ***911 is always called if Epi-Pen is administered***

Special instructions: _____

By signing below, I authorize school personnel to implement this bee sting plan as described above. I give permission for exchange of health information in relation to this allergy with my child's physician. I also understand staff may be notified of allergy to help maintain my child's health and safety at school. I further understand that all costs of emergent medical treatment provided shall be my sole responsibility as the student's parent/guardian.

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____