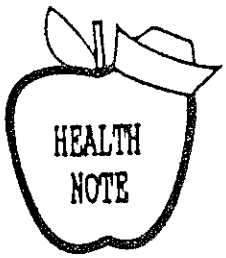

Union Township School Corporation
Health Services

ALLERGY to INSECT STING

Dear Parent (Guardian) of _____, Date_____

You notified the school that your child has a history of allergic symptoms to insect stings. Please describe in detail the symptoms that have occurred. If your doctor has prescribed specific use of emergency medications, ask your doctor to complete the authorization provided. Your timely response to this letter will help individualize your child's care. All medications must be provided in original labelled containers.

Thank You! Sincerely,

School Phone No. _____ _____, R.N.

* *

Past symptoms when child was stung + last date:_____
_____
Actions to be taken if child is stung:_____
_____

Please call the following people:
(1)_____Phone:_____Relationship:_____
(2)_____Phone:_____Relationship:_____

I understand that should I or designated persons not be available, School personnel will contact Emergency Medical Services for care at my expense.
Date: _____ Parent (Guardian) Signature:_____

* *

MEDICAL AUTHORIZATION OF CARE AFTER INSECT STING

Student:_____School:_____

☐ Oral Benadryl dose _____

☐ Epipen Jr 0.15cc to be given immediately by trained school staff.

☐ Epipen 0.3cc to be given immediately by trained school staff.

☐ Student may carry and self-administer Epipen (Applies to middle and high school students. Elementary schools store meds in clinic.)

Follow Up Care: _____
_____
_____

Date:_____ Dr. Signature & Phone _____