UNION TOWNSHIP SCHOOL CORPORATION
HEALTH SERVICES

ALLERGY TO INSECT STING ACTION PLAN

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, we must have the authorization below filled out and signed by the doctor. Your timely response will help individualize your child's care. All medications must be provided in original labelled containers. Thank you.

Past symptoms when child was stung and last date/Treatment_____
_____

Actions to be taken if child is stung:_____
_____

Contact the following people:

1._____**Phone**_____**Relationship**_____
2._____**Phone**_____**Relationship**_____
3._____**Phone**_____**Relationship**_____

I understand that should I or emergency contacts not be available, school personnel will contact Emergency Medical Services for care at my expense.
Date_____**Name**_____

MEDICAL AUTHORIZATION FOR CARE AFTER INSECT STINGS

Student Name_____

- ❑ **Oral Benadryl dose**
- ❑ **Epipen 0.3 mg to be given immediately by trained school staff.**
- ❑ **Epipen Jr. 0.15 mg to be given immediately by trained school staff.**
- ❑ **Student may carry and self-administer Epipen.**

Follow up care_____

Date_____**Phyisican Signature**_____
Print Physician Name_____
Physician Phone_____