

MOUNT PLEASANT CENTRAL SCHOOL DISTRICT

825 West Lake Drive
Thornwood, NY 10594

Phone (914) 769-5500 • Fax (914) 769-3733

Bee Sting Medication Form

Student: _____ Grade: _____ School Contact: _____ 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 ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- MOUTH Itching & swelling of lips, tongue or mouth
- THROAT Itching, tightness in throat, hoarseness, cough
- SKIN Hives, itchy rash, swelling of face and extremities
- STOMACH Nausea, abdominal cramps, vomiting, diarrhea
- LUNG Shortness of breath, repetitive cough, wheezing
- HEART "Thready pulse", "passing out"

Student
Photo

The severity of symptoms can change quickly – it is important that treatment is give immediately.

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

TREATMENT: 1. Remove stinger if visible; apply ice to area. 2. Rinse contact area with water.

Treatment should be initiated with symptoms without waiting for symptoms

Benadryl ordered: Yes No Give _____ Benadryl per provider's orders

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

Epinephrine ordered: Yes No Special instructions: _____

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.

Preferred Hospital if transported: _____

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.

Transportation Plan: Medication available on bus Medication NOT available on bus Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

Copy provided to Parent

Copy sent to Healthcare Provider

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

This plan is in effect for the current school year and summer school as needed.