Jackson Local Schools

STINGING INSECT ALLERGY ACTION PLAN

Student's Name: ______________________ DOB: ______________

Grade: ________ Teacher: ______________________ School Year: ______________

- Date of last reaction to bee/wasp/hornet sting: ______________________
- What does a **"typical"** reaction to the sting look like: ______________________

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- Does your child have an epinephrine auto-injector at school? ☐ Yes ☐ No
- Where is epinephrine auto-injector stored? ☐ Clinic ☐ Student has authorization to carry
- Has your child been trained on the proper use of the epinephrine auto-injector? ☐ Yes ☐ No
- Is your child **asthmatic**? ☐ Yes (higher risk for severe reaction) ☐ No
  ** If your child is asthmatic or requires an inhaler for allergic reactions, please complete the Asthma Action Plan.

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

☐ Hives, itchy rash, swelling of face or extremities
☐ Swelling at site (local)
☐ Severe pain at site of sting
☐ Itching, tingling, or swelling of lips, tongue, mouth
☐ Red, itchy, watery eyes
☐ Shortness of breath, repetitive coughing and wheezing
☐ Other (describe) ______________________

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♦ROUTINE STINGING INSECT PROCEDURE FOR ALL STUDENTS♦

- Check Student Health Concern List to see if student is allergic to stings.
- If student has a known allergy to stings, notify parent immediately and follow emergency procedure 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 affected area.
- Observe student in office for 5-10 minutes for allergic reaction.
- If no reaction is present after observation time, student may return to class. Classroom teacher should be notified that a student was stung to watch for delayed reactions. Contact parents to report bee sting.

♦EMERGENCY PROCEDURE FOR ALLERGIC STUDENTS♦

(must be completed by the prescribing physician)

☐ **Administer Antihistamine:** ______________________
(Medication/Dose/Route)

☐ **Administer Other Medication:** ______________________
(Medication/Dose/Route)

☐ **Epinephrine Intramuscular Injection:** (circle one) Epinephrine 0.15mg Epinephrine 0.3 mg

****Note: Emergency Medical Services will be contacted if an epinephrine auto-injector is administered. ****

I give permission to the school nurse and other designated staff members of Jackson Local Schools to perform the health management tasks as outlined by this Individualized Health Plan. I also consent to the release of the information contained in this plan to all staff members who have custodial care of my child and may need to know this information to maintain my child's health and safety while at school and extracurricular activities.

Parent/Guardian Signature: ______________________ Date: ____________

Physician Signature/Phone: ______________________ Date: ____________

Ohio Department of Health

Authorization for Student Possession and Use of an Epinephrine Autoinjector

In accordance with ORC 3313.718/3313.141

A completed form must be provided to the school principal and/or nurse before the student may possess and use an epinephrine autoinjector to treat anaphylaxis in school.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.

Parent /Guardian signature	Date
Parent /Guardian name	Parent /Guardian emergency telephone number ( )

This section must be completed and signed by the medication prescriber.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Circumstances for use of the epinephrine autoinjector
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

As the prescriber, I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )

Developed in collaboration with the Ohio Association of School Nurses.

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