INDIVIDUALIZED HEALTH PLAN
BEE STING MANAGEMENT

Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name:_____ Date of Birth:_____ School Year:_____

School:_____ Grade:_____ Classroom Teacher:_____

Parent/Guardian Name:_____ Tel. (H):_____ (C):_____

Other Emergency Contact:_____ Tel. (H):_____ (C):_____

Child's Primary Care Dr.:_____ Tel:_____ Location:_____

Child's Specialty Dr.:_____ Tel:_____ Location:_____

Significant medical history or conditions:

BEE STING INFORMATION:

1. Is your child's bee sting allergy considered life threatening? ☐ Yes ☐ No _____

2. Describe how your child reacts to a bee sting.
   ☐ Local swelling ☐ Hives ☐ Difficulty breathing ☐ Other _____

3. Has your child received medical care because of a bee sting? ☐ Yes ☐ No
   Health Care Provider _____
   Approximate Date _____

BASIC FIRST AID:

- ☐ Observe 30 minutes
- ☐ Apply ice
- ☐ Notify parents
- ☐ Give antihistamine _____
  Name dosage when
- ☐ Other _____
- ☐ If reaction progresses – give **EPI-PEN**

EMERGENCY RESPONSE:

- ☐ Give **EPI-PEN** immediately upon getting stung
- ☐ Call 911
- ☐ Notify parent
- ☐ If antihistamine given contact parents immediately.

EPI-PEN

Can the student self-administer? ☐ Yes ☐ No

Location of **EPI-PEN**

- ☐ Office
- ☐ Student locker
- ☐ Back pack
- ☐ Other: _____

Antihistamine is located in:

- ☐ Office
- ☐ Student locker
- ☐ Back pack
- ☐ Other: _____

EMERGENCY CALL:

After giving an EPI-PEN, 911 will be called. State that a bee sting allergic reaction occurred, has been treated, and needs transport to the Emergency Room to be evaluated.

If medication is given at school, a medication consent form signed by parent and child's medical provider must be on file each school year. All medications must be supplied by parent.

This information will be shared with classroom teacher(s) and other appropriate school personnel.

Parent/Guardian Signature:_____ Date:_____

School Nurse Signature:_____ Date of Review:_____

Attach medication sheet – one is needed for each medication