Bee or Insect Allergy Form

student's Name:_____ Date of Birth: _____ Grade: _____

Parent/ Guardian: _____ Phone: _____ Cell/Work: _____

Health Care Provider name treating bee/insect allergy: _____ Phone: _____

Has your child's **health care provider** told you the allergy may be **life-threatening**? □No □ Yes

History and Current Status

What type of stinging bee or insect has your child reacted to? _____

How many times has your child had a reaction? □Never □ Once □ More than once, please describe:_____

_____

When was the last reaction? _____

Are the reactions: □ staying the same □ getting worse □ getting better

Has your child ever needed treatment at a clinic or the hospital for an allergic reaction □ No □ Yes, please describe: _____

_____

Triggers and Symptoms

What are the signs and symptoms of your student's allergic reaction? *(Be Specific; include things your child might say.)*

_____

How quickly do the signs and symptoms appear after the sting ____ seconds ____minutes _____ hours _____ days

Treatment

What do you do at home if there is a reaction to a bee sting or insect bite? _____

Symptoms that require Antihistamine (Benadryl): _____

Medication_____ Dose_____

Symptoms that require Epinephrine: _____

What treatment or medication has your health care provider recommended for an allergic reaction?

_____ □ None

Have you used the treatment or medication? □ No □ Yes

Does your child know how to use the treatment or medication? □ No □ Yes

If medication is needed at school, have you brought the medication or treatment supplies to school and filled out appropriate medication forms?

□Yes

□No, I need to get the form, have it completed by a health care provider, and return to school.

Emergency Calls

1. Call 911 (always call 911 if Epinephrine has been used)
2. Parent/Guardian_____ Phone(s) _____
3. Dr. _____ Phone number _____
4. Emergency Contacts

   Name_____ Phone number(s)_____

   Comments/Other _____

- I release school staff from any liability in the administration of this medication at school
- All Medication supplies must come in its originally provided container
- Medication information may be shared with school staff working with your child
-

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____
Required

WILMINGTON AREA SCHOOL DISTRICT
300 Wood Street New Wilmington, Pennsylvania 16142
(724) 656-8866
MS/HS School Nurse – Ext. 1030
Elementary School Nurse – Ext. 3030

EPI-PEN SELF-ADMINISTRATION BY STUDENT

Student's Name_____ Grade/Homeroom _____

Name of Medication_____ Date Prescribed_____

Diagnosis/Reason_____ Length of Need _____

Side Effects/Special Circumstances _____

To self-medicate, the student must be able to: (check all that apply)

☐ 1. Respond to and visually recognize his/her name.
☐ 2. Identify his/her medication.
☐ 3. Demonstrate the proper technique for self-administering his/her medication.
☐ 4. Sign his/her medication log to acknowledge having taken the medication.
☐ 5. Demonstrate a cooperative attitude in all aspects of self-administration.

The above named student has demonstrated the ability to self-administer the physician prescribed epi-pen, as indicated by the criteria above.

_____ _____
Physician's Signature Date

_____ _____
Certified School Nurse's Signature Date

As parent/guardian of the above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/sharing of the above name medication will result in the immediate confiscation of the epi-pen and loss of privilege to self-administer if the medication policy is violated. The student shall notify the school nurse following each use an epi-pen.

_____ _____
Parent/Guardian's Signature Date

_____ _____
Student's Signature Date

THIS FORM MUST BE ATTACHED TO AN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION FORM AND AN EPI-PEN ACTION/CARE PLAN

WILMINGTON AREA SCHOOL DISTRICT

400 WOOD STREET
NEW WILMINGTON, PA 16142

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Student's Name_____ DOB_____

Building_____ Grade/Homeroom_____

Name of Medication (A separate form must be completed for EACH medication that is to be administered)_____

_____

Dosage_____

Desired time of administration_____

Special circumstances of Side effects_____

Listing of other medications prescribed for student _____

_____

Period of time for which medication is prescribed_____

Prescribing Physician's Name _____

Prescribing physician's signature OR copy of signed prescription attached

_____OR

Signed Prescription attached:_____

I hereby agree to hold harmless and indemnify the Wilmington Area School District and its employees against any and all claims, damages, expenses, attorney's fees, suits, cause or causes of action in law or equity for the administration of the medication authorized above.

_____ _____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian Date

Amount of Medication received _____

By_____ _____

Signature Date

NOTE: ALL MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL PRESCRIPTION/MANUFACTURER'S BOTTLE OR IT WILL NOT BE ADMINISTERED AT SCHOOL.

Emergency Care Plan

Name:_____ DOB:_____

School:_____ Grade:_____

Parent/Guardian Emergency Contact:_____

Telephone (h):_____(w):_____(cel)_____

Parent/Guardian Emergency Contact:_____

Telephone (h):_____(w):_____(cel)_____

Emergency Contact (if Parent/Guardian not available)/Relationship/Telephone Number:

_____

Healthcare Provider/Telephone:_____

KNOWN ALLERGIES:_____

_____

HEALTH PROBLEM:_____

IN A HEALTH EMERGENCY (STUDENT) LOOKS LIKE:

_____

_____

_____

PLEASE DO THE FOLLOWING:

_____

_____

_____

_____

_____

Parent/Guardian Signature:_____Date:_____

Certified School Nurse Signature:_____Date:_____