"We Inspire and Empower Learners"

NORTH ROYALTON CITY SCHOOLS
6579 Royalton Road
North Royalton, Ohio 44133

Bee/Wasp/Hornet Sting Allergy

Dear Parent/Guardian:

You have indicated that your child has a severe allergy to bee/wasp/hornet stings. A severe allergy is classified as requiring emergency medication (EpiPen/Benadryl) in the event of a sting. Please complete the attached **INSECT STING ALLERGY PLAN** if your child has a severe allergy and return it as soon as possible to the school's clinic. The information will only be shared with the appropriate personnel such as your child's classroom teacher(s) and physical education teacher. This information that you provide will help to ensure the health and safety of your child.

Students are permitted to carry and administer their own Epinepherine Autoinjector, provided that the physician AND parent authorize the student to do so in writing AND a spare dose is on file in the school clinic per Ohio Revised Code (3313.718). Benadryl is not an emergency drug therefore must be kept in the clinic.

If your child:

- No longer has an allergy to a bee sting, please handwrite a note and forward it to the school clinic as soon as possible so that we may remove his/her name from our list.

Or

- Does not require medication to treat the allergy, please handwrite a note regarding this special circumstance including the treatment that should be provided and forward it to the school clinic as soon as possible.

Please inform the school's clinic of any changes in your child's health condition or medication schedule should a change arise.

Thank you,

Carolyn Baetjer RN

Carolyn Baetjer, RN BSN NCSN
District Health Coordinator
North Royalton City Schools
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North Royalton, Ohio 44133
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NSG-202B
Rev. 01-2016

NORTH ROYALTON CITY SCHOOLS
BEE/WASP/HORNET ALLERGY PLAN
* CONFIDENTIAL*

☐ Addendum Attached

_____ _____
Received by Date

Student's Name	Student's Date of Birth	Grade
Allergy to:		School Year

Asthmatic: YES* ☐ or NO ☐ (Please check one) *Higher risk for severe reaction

Child's Picture

STEP 1: TREATMENT (To be completed by physician)

SYMPTOMS:	GIVE CIRCLED MEDICATION: (TO BE DETERMINED BY PHYSICIAN)	
If a sting has occurred, but **NO SYMPTOMS**:	Epinephrine	Antihistamine
Mouth: Itching, tingling, or swelling of lips, tongue	Epinephrine	Antihistamine
Skin: Hives, rash, swelling of face or extremities	Epinephrine	Antihistamine
Gut: Nausea, cramping, vomiting, diarrhea	Epinephrine	Antihistamine
Throat*: Tightening of throat, hoarseness, cough	Epinephrine	Antihistamine
Lung*: Shortness of breath, coughing, wheezing	Epinephrine	Antihistamine
Heart*: Thready pulse, low blood pressure, fainting	Epinephrine	Antihistamine
Other:	Epinephrine	Antihistamine
If reaction is progressing or several of the above areas are affected, give:	Epinephrine	Antihistamine

Potentially life-threatening. 911 WILL BE CALLED IF EPIPEN IS ADMINISTERED

Inject Epinepherine Intramuscularly: (indicate dosage)

- ☐ **Epinepherine Autoinjector 0.3 mg**
- ☐ **Epinepherine Autoinjector 0.15 mg**

Antihistamine:_____
(Name/Dose/Route)

List any accommodations required:

STEP 2: EMERGENCY CALLS

1. Call 911 and state that an allergic reaction has been treated with:_____
(Name of Drug)

2. Call Parent/Guardians:

Name/Relationship	Phone Number(s)	
a.	1.	2.
b.	1.	2.
c.	1.	2.

3. Notify Dr._____ **at** _____
(Name) **(Phone Number)**

I, AS PARENT/GUARDIAN, GIVE PERMISSION FOR SCHOOL PERSONNEL TO FOLLOW THIS PLAN, ADMINISTER MEDICATION (IF ANY) AND CARE FOR MY CHILD AND CONTACT MY PHYSICIAN IF NECESSARY. I ASSUME FULL RESPONSIBILITY FOR PROVIDING THE SCHOOL WITH PRESCRIBED MEDICATION AND DELIVERY/MONITORING DEVICES. I APPROVE THIS EMERGENCY ALLERGY PLAN FOR MY CHILD. I ALSO CONSENT TO THE RELEASE OF THE INFORMATION CONTAINED IN THIS PLAN TO ALL STAFF MEMBERS AND OTHER ADULTS WHO HAVE CUSTODIAL CARE OF MY CHILD AND WHO MAY NEED TO KNOW THIS INFORMATION TO MAINTAIN MY CHILD'S HEALTH AND SAFETY.

Parent/Guardian(s) Signature	Date
Physician's Signature	**Date**

********AUTHORIZATION FOR STUDENT POSSESSION AND USE OF EPINEPHRINE AUTO-INJECTOR***********

To be completed ONLY if student will be self-carrying Epinephrine Auto-injector

(In accordance with ORC 3313.718/8313.141)

This form must be completed in its entirety. The administration of prescription medication requires a physician's and parent/guardian permission.

Student Name	Date of Birth
Student Address	

This section must be completed and signed by parent or guardian: As parent/guardian of this student, I authorize my child to possess and use an epinephrine auto-injector, as prescribed, at school and any activity, event, or program sponsored by or in which the student's school is a participant. I agree to comply with Board policy and regulations regarding self-administration of medication. I also agree to submit a revised authorization if any of the information contained in this document should change. I understand that pursuant of Ohio Revised Code, Section 3316.716, the Board and its employees are not liable for my child's self-administration of this medication. 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 back-up dose of the medication to the school as required by law.***

Parent/Guardian Signature	Date
Parent/Guardian printed name	Parent/Guardian emergency phone number ( )

This section must be completed and signed by medication prescriber/health care provider:

Name of medication	Dosage of medication
Start date:	End date:
Circumstances for use of epinephrine auto-injector:	
Procedure for school staff to follow if student is unable to administer this medication or if it does not produce the expected relief:_____ _____ _____	
Possible severe adverse reactions to student for which it is prescribed:	
Possible severe adverse reactions to UNAUTHORIZED user:	
Special instructions:	

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

Prescriber signature	Date
Prescriber name	Prescriber emergency telephone number ( )