FT. ZUMWALT SCHOOL DISTRICT

Insect Allergy Form

Student Name: _____Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating insect allergy:_____ Phone: _____

Do **you think** your child's insect allergy may be **life-threatening**? ☐No ☐Yes

(If Yes, please see the school nurse as soon as possible.)

Does your child's **health care provider think** the insect allergy may be **life-threatening**? ☐No ☐Yes

(If Yes, please see the school nurse as soon as possible.)

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:

_____

Has your child ever received or used an Epi-pen® or other injection as treatment? ☐No ☐Yes, please describe:

_____

Triggers and Symptoms

What are the signs and symptoms of your child'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

Does your child understand how to avoid getting a bee sting or insect bite? ☐No ☐Yes

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

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

Please describe any side effects or problems your child had in using the suggested treatment or medication.

_____

If medication is to be available at school, have you filled out a medication form for school?

☐Yes

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

If medication is needed at school, have you brought the medication or treatment supplies to school?

☐Yes

☐No, I need to get the medication/treatment and bring it to school.

What do you want the school to do in case of a bee sting or insect bite? _____

X Parent/Guardian Signature: _____ Date: _____

Adapted from OSPI Anaphylaxis Guidelines

Insect Allergy
Action Plan

Place Child's Picture Here

Student Name_____ D.O.B. _____ Teacher: _____

Allergy to: _____

Asthmatic ☐Yes* ☐No *Higher risk for severe reaction

STEP 1: Treatment

Symptoms:		**Give Checked Medication**** (TO BE DETERMINED BY PHYSICIAN AUTHORIZING TREATMENT)	
• If an insect sting has occurred, but no symptoms		☐Epinephrine	☐Antihistamine
• Site of sting	Swelling, redness, itching	☐Epinephrine	☐Antihistamine
• Skin	itching, tingling, or swelling of lips, tongue, mouth	☐Epinephrine	☐Antihistamine
• Gut	nausea, abdominal cramps, vomiting, diarrhea	☐Epinephrine	☐Antihistamine
• Throat†	tightening of throat, hoarseness, hacking cough	☐Epinephrine	☐Antihistamine
• Lung†	shortness of breath, repetitive coughing, wheezing	☐Epinephrine	☐Antihistamine
• Heart†	thread pulse, low blood pressure, fainting, pale, blueness	☐Epinephrine	☐Antihistamine
• Mouth	if an insect sting has occurred, but no symptoms	☐Epinephrine	☐Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐Epinephrine	☐Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Antihistamine: give _____
MEDICATION / DOSE / ROUTE

Epinephrine: give _____
MEDICATION / DOSE / ROUTE

STEP 2: Emergency Calls

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____at _____.
3. Emergency contacts:

Name / Relationship	**Phone Number(s)**
a. _____	1.) _____2.) _____
b. _____	1.) _____2.) _____
c. _____	1.) _____2.) _____

EVEN IF A PARENT / GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

X Parent / Guardian Signature _____ Date _____

X Doctor's Signature _____ Date _____
(REQUIRED)

Physician Name: _____Specialty: _____ Physician Phone: _____