HOWARDS GROVE SCHOOL DISTRICT-CONFIDENTIAL HEALTH INFORMATION

School Year_____ **INSECT STING HEALTH ACTION PLAN**

Student Name_____

Date of Birth_____ Grade_____ Grad Year_____

School_____ Teacher/HR_____

PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____ H/C/W Name/ Relationship _____

Phone 2. _____ H/C/W Name/ Relationship _____

Phone 3. _____ H/C/W Name/ Relationship _____

Phone 4. _____ H/C/W Name/ Relationship _____

Address for Health Plan updates:_____

Email for Health Plan updates: _____

ALLERGY:_____

Physician student sees for Allergy_____ Phone Number_____

Asthmatic? Yes____ No____ (If yes, student has higher risk for severe allergy)

Please check symptoms your child has during a severe allergic reaction:

___Hives/rash ___Chest tightness ___Shortness of breath ___Nausea/vomiting
___Itching ___Dizziness ___Swelling at the site ___Unconsciousness
___Flushed face ___Cough ___Drooling ___Cramping/Abdominal Pain
___Swelling of extremities ___Swelling of lips, tongue, throat, eyes, face
___Other_____

Onset of symptoms after contact:

___Immediately ___Within 15 minutes ___Within an hour ___Within 2 hours ___Unknown/Varies

Does your child require an antihistamine at school? Yes____ No____ Location:_____

Medication/Dose:_____

Does your child require Epinephrine while at school? Yes____ No____ Location:_____

Can your child self-administer Epinephrine at school? Yes____ No____

(Middle/High School students only with doctor approval)

For Staff Use

Has your child ever need Epinephrine to treat symptoms? Yes___ No____

Explain:_____

_____

NOTE: Parents are responsible for providing medication to be given during school. A Medication Authorization Form needs to be filled out and signed by a health care provider and parent annually. Medications must be in the original labeled container.

PLEASE COMPLETE & SIGN NEXT PAGE

STUDENT NAME:_____ **DATE OF BIRTH:**_____

EMERGENCY ACTION PLAN FOR STAFF

IF YOU SEE THIS: MILD REACTION_____

Do This:

- Have student come to office with an escort
- Put ice on sting. Make sure stinger is removed
- Call parent/guardian to inform them of situation and administer student's antihistamine on file (if applicable)
  Give _____mg _____ by mouth.
- Locate the student's epinephrine pen (if applicable)
- Continue to monitor student for 20-30 minutes & observe for any symptoms of **anaphylaxis (see below)**

IF YOU SEE THIS: ANAPHALYAXIS, SEVERE ALLERGIC REACTION

Mouth: Itching, tingling or swelling of lips, tongue, or mouth
Throat: Itching or tightening in the throat, horseness, hacking cough
Skin: Hives, itchy rash, swelling of the face or extremities
Gut: Nausea, abdominal cramps, vomiting, diarrhea
Lung: Shortness of breath, hacking cough, wheezing
Heart: Weak or irregular pulse, dizziness, low blood pressure, pale, blue

DO THIS FOR SEVERE ANAPHYLACTIC REACTION:

- **Call the school office to have the EpiPen brought to the student's location immediately**
- **Have the school office call a "Medical Support" Response and call 911**
- **Administer the Epipen immediately. May repeat with a second EpiPen (if available) after 5-20 minutes**
  - Dispose of needle and injector in red sharps container
  - Give Epipen packaging and copy of this health plan to emergency response personel
- Notify parent/guardian (EpiPen administration/calling 911 priority to be done first)
- Notify building principal if not already aware
- Complete an accident/incident report AND Medical Support Report Form

Comments/Special Instructions:_____

Memo of Understanding:

- It is understood that a parent will complete and sign an Allergy Health Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the school district of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Date _____

Building Administrator:_____ Date _____

Physician Signature (if applicable): _____ Date _____