Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956

Insect Sting Emergency Plan

Picture

Student_____ Date_____ Grade_____

Date of Birth_____ School_____ Teacher_____

Address_____ Parent/Guardian_____

City_____ Zip Code_____ Home Phone_____

Emergency Contacts:

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Name_____ Number_____ Relationship_____

Allergy To: _____

Section 1: SYMPTOMS

Symptoms of an allergic reaction may include any of the following:

- MOUTH: Itching & swelling of lips, tongue or mouth
- THROAT: Itching, tightness in throat, hoarseness, cough
- SKIN: Hives, itchy rash, swelling of face and extremities
- STOMACH: Nausea, abdominal cramps, vomiting, diarrhea
- LUNG: Shortness of breath, repetitive cough, wheezing
- HEART: Pale, blue, faint, weak pulse, dizzy

Describe known signs and symptoms from any previous insect sting(s):

_____

_____

Section 2: PROCEDURE

Treatment should be initiated: ☐ With Symptoms ☐ Without Symptoms

1. Give medication as indicated.
2. If Epinephrine given, call 911.
3. Additional Epinephrine may be needed, repeat epi-injector after 5-10 minutes if symptoms continue.
4. Stay with student and monitor condition.
5. Notify parent/guardian.
6. Transport to hospital of choice: _____

- OVER-

Section 3: MEDICATION **(to be completed by physician)**

Epinephrine - Inject IM (circle one): EpiPen Jr. – 0.15 mg EpiPen – 0.3 mg Auvi-Q - 0.15 mg Auvi-Q - 0.3 mg

Epinephrine expiration date: _____

Antihistamine - give medication name/dose/route: _____

Antihistamine expiration date: _____

Other – give medication name/dose/route: _____

*All over the counter medications must be in the original container.
*All prescription medications must be in a properly labeled pharmacy box.

IMPORTANT: Asthma inhalers and antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date_____

Physician Information

Print Name of Provider_____ Clinic Name_____
Phone Number_____ Fax Number_____
Address_____

Signature of Provider_____ Date_____

Revised 4/2017