School District of Iola-Scandinavia-Confidential

Health Services: Bee Action Plan

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

My Child's Reaction may include :(Please check all that apply)

___Wheezing ___Shortness of breath ___Coughing ___Hoarseness

___Headache ___Itchy Skin/Hives ___Stomach Pain ___Nausea/Vomiting

___Swelling or flushing of lips, throat, tongue, hands, or feet ___Other:______________________

Reaction will occur:

___Within a few minutes

___Within 30 minutes to 2 hours

___Other-Please list: ____

Please tell us what you want us to do in case of a reaction at school: (Please check all that apply)

___Remove stinger

___Apply Ice to affected area

___Allow to rest and monitor student

___Notify parent

___Call 911 (Per school policy, if an Epi-Pen/Auvi-Q is used, 911 will be called)

___Is student allowed to self-administer (Must have doctor approval) YES___ or NO___

___Administer medication*

Name of medication and Dosage:

1.____

2.____

*If your child requires a prescribed medication, you must have a MEDICATION AUTHORIZATION FORM signed by you and your child's doctor on file for THIS school year **Please fill out reverse side…**

Date of last BEE STING REACTION: ____________________

Any additional information you would like us to know: ____

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Parent/Emergency Contact Information:

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
Email address:	Email address:	Email address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse and/or office staff as soon as possible.

Parent/or legal guardian Signature: _______________________________Date: ________________________

School Nurse Signature: ____ Date: ________________________