



Bellevue Public Schools

B

NRS 1029-3/23

Insect Sting Allergy Action Plan

Student information

Student's name _____ Date of Birth _____
School _____ Grade _____

Please complete this form with current information about your student's insect sting allergy, including actions to take should a problem arise. A new action plan is required each school year to be completed on or after May 1.

Contact information

Parent/Guardian 1 _____
Telephone Home _____ Work _____ Cell _____
Email address _____

Parent/Guardian 2 _____
Telephone Home _____ Work _____ Cell _____
Email address _____

Student's physician/health care provider _____
Address _____
Telephone _____ Fax _____

1. Your student's brief insect sting allergy history and potential reaction if stung: _____

2. What response is required should your student experience an insect sting at school? _____

3. Is your student's allergy so severe that it requires treatment with emergency medication?
(i.e., use of an EpiPen) Yes No

If medication is required at school, please provide the medication with the "Permission for Administration of Medication by School Personnel" form.

Note: If a student's parent/guardian and physician requests that the student self-manage his/her anaphylaxis condition at school, a self-management of anaphylaxis consent/release form must be completed and kept on file at the school. This is required by law.

PLEASE COMPLETE BACK OF PAGE

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Student's Last Name _____

Student's First Name _____

Severity of symptoms can change rapidly and become life-threatening!

Symptoms of Severe Reaction:

Please **circle** your student's symptoms.

Hives/itching over whole body
Facial/mouth swelling
Increased anxiety
Hoarseness/sense of tight throat

Wheezing
Difficulty breathing/shortness of breath
Loss of consciousness/thready breath
Abdominal cramps/nausea

Procedures for Severe Reaction

1. Call 911 EMS.
2. Administer medication if ordered _____
3. Remove stinger, if present.
4. Reassure student.
5. Apply ice/instant ice from first aid kit if out of building.
6. Notify school nurse and parent/guardian.
7. If the student does not get better or continues to get worse, use Nebraska Schools' Emergency Response to Life Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol (at school, during school hours).

Additional comments: _____

Procedures for Mild Reaction

1. Remove stinger, if present.
2. Administer medication if ordered _____
3. Apply ice/instant ice from first aid kit if out of building.
4. Monitor student, watch for signs of progression to severe reaction (refer to above).
5. Notify school nurse and parent/guardian.
6. Alert appropriate staff to watch for progression of symptoms.

Additional comments: _____

I understand and agree this information will be reviewed by the school nurse and shared with school staff when appropriate. The school nurse may contact you or your student's physician/health care provider if additional information or clarification is needed. I authorize the school nurse or designated personnel to follow this insect sting allergy action plan and administer medications as detailed in this plan.

Physician signature _____ Date _____

Parent/Guardian signature _____ Date _____

Reviewed by school nurse _____ Date _____

