

**FOOD AND BEE STING ALLERGY TREATMENT PLAN AND
THE PERMISSION FOR THE ADMINISTRATION OF MEDICATION BY
SCHOOL PERSONNEL**

STUDENTS NAME: _____ DOB _____

ADDRESS: _____ TEL # _____

PHYSICIAN: _____ PHYSICIANS TEL # _____

Does this child have Asthma? Yes ___ No ___

SPECIFIC ALLERGY: _____

IF STUDENT HAS BEEN STUNG BY A BEE OR HAS INGESTED THE ABOVE NAMED FOOD:

_____ Observe student for signs of anaphylaxis x 2 hours

_____ Administer **adrenaline** before symptoms occur. EpiPen Jr. Adult

_____ Administer **adrenaline** if symptoms occur. EpiPen Jr. Adult

_____ Administer Benadryl ___ tsp.

_____ Administer _____

_____ Call 911, transport to ER if symptoms occur for evaluation, treatment and observation.

IF REACTION OCCURS,
PLEASE NOTIFY THIS OFFICE

Physicians Signature

Date

1. Is this a controlled drug? Yes ___ No ___

2. Medication shall be administered from _____ to _____

3. Relevant side effects to be observed: _____

4. Please allow student to self-administer medication (must meet the guidelines of self medication assessment). _____

Signature _____ MD

Parent Signature _____ Date _____

SYMPTOMS OF ANAPHYLAXIS:

**Chest tightness, cough, shortness of breath, wheezing
Tightness in throat, difficulty swallowing, hoarseness
Swelling of lips, tongue and throat
Itching mouth, itchy skin, hives or swelling
Stomach cramps, vomiting, diarrhea
Dizziness or faintness**