BUCKEYE LOCAL SCHOOL DISTRICT
BUCKEYE LOCAL BOARD OF EDUCATION
3044 Columbia Road
Medina, Ohio 44256
Phone: 330-722-8257

Insect Allergy Action Plan

Student's Name:	School/Grade:
Date of Birth:	Contact Teacher:
Parent/Guardian Name:	Phone (Family):
Address:	
Physician:	RN:
Emergency Number:	

Allergy to: ____

Weight: ________ **lbs**. **Asthma:** _____ **Yes (higher risk for a severe reaction)** _____ **No**

☐ The student is capable of possessing and using the auto injector appropriately per MD orders.

☐ The student has been trained on the proper use of auto injector.

* If either of the above boxes are **NOT** checked student may **NOT** carry auto injector.
One epinephrine auto-injector is **REQUIRED to be stored in the school clinic.

1. Any SEVERE SYMPTOMS after suspected sting:

<u>One or more</u> of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body
Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

Treatment:
1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin Monitoring
4. Give additional medications (if ordered)
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthma

2. MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

Treatment:
1. GIVE ANTIHISTAMINE
2. If symptoms progress (see above), USE EPINEPHRINE
3. Begin monitoring

Medications/Doses

Epinephrine (brand and dose): ____

Antihistamine (brand and dose): ____

Other (e.g., inhaler-bronchodilator if asthmatic): ______________________________

This plan is subject to change but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff and transportation that are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if the health status of the student listed above changes, we change physicians, or there is a change or cancellation of the physician's orders.

Parent/Legal Guardian ______________________ Date ______________________
Registered Nurse ______________________________ Date ________________

MEDICAL REVIEW
I have reviewed the attached Action Plan for ______________________, AND:

_______ I approve the Action Plan as written.

_______ I approve the Action Plan with the attached amendments.

_______ I do <u>not</u> approve of the Action Plan as written, and substitute orders are attached.

Physician ______________________________ Date ______________________

Other Recommendations

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Copies to: Board Office Bus Garage Teacher Other _____________