Waterford School District – Plan of Care (POC) - Insect Sting Management

Bus Route #: _____

Student Name: _____ School: _____ Grade: _____

Signs of an allergic reaction include the following (items that are checked are ones usually experienced by the student when having a **MINOR** reaction.)

*Mouth: ☐Itching and Swelling of the Lips ☐Tongue ☐Mouth
*Throat: ☐Itching ☐Sense of Tightness in the Throat ☐Hacking Cough
Skin: ☐Hives ☐Itchy Rash ☐Swelling about the Face or Extremities
Gut: ☐Nausea ☐Abdominal Cramps ☐Vomiting ☐Diarrhea
*Lung: ☐ Shortness of Breath ☐Repetitive Coughing ☐ Wheezing
*Heart: ☐Thready Pulse ☐Fainting

*The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation. If the student experiences only the above checked items suspect a minor reaction and:

- Escort him/her to the main office immediately.
- Administer Medication _____
  (Doctor, please identify the type of medication you wish to be administered)
- Phone parents
- Observe for any changes including development of more symptoms until the parent arrives.

If the suspect student experiences swelling of the throat, hard time breathing or any of the following symptoms:
(Doctor, please identify the type of symptoms you would expect to see in a MAJOR reaction)

_____ _____ _____ _____

Or if you are sure the student was stung:

- **Inject one (1) Epi-Pen immediately** (you may have to hold the student down)
- **Call 911**
- **If the stinger is in skin, remove by gently scraping. DO NOT PUSH, SQUEEZE, OR PINCH.**
- **Apply ice pack**
- **Notify parents**
- **Monitor closely until help arrives**
- **Send a copy of this form and used Epi-Pen with student to hospital**

Call Parents: Home Phone: _____

Mother: _____Cell Phone: _____Work Phone:_____

Father: _____Cell Phone: _____Work Phone:_____

In the event that special accommodations are required, the school district may need up to five (5) school days to comply with the request. It will be up to the parent and the physician to determine if the child shall attend school during that time.

_____ _____ _____ _____
PARENT SIGNATURE DATE PHYSICIAN SIGNATURE DATE

Physician Name _____

Physician Address_____

Physician Phone _____

Rev. 07/01/09 Copy: Security, School File

Note: This plan will be shared with all appropriate school district staff.