HEALTH NOTE

Union Township School Corporation
Health Services

ALLERGY to INSECT STING

(Bee, Wasp, Mosquito, etc.)

Date:____________________

Dear Parent (Guardian) of:____________________,

You notified the school that your child has a history of allergic symptoms to insect stings. Please describe in detail the symptoms that have occurred. If your doctor has prescribed specific use of emergency medications, ask your doctor to complete the authorization provided. Your timely response to this letter will help individualize your child's care. All medications must be provided in original labelled containers.

Thank You.
School Phone #:____________________

Sincerely,
____________________R. N.

Past symptoms when child was stung + last date: ____________________

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Actions to be taken if child is stung:____________________

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Please call the following people:

(1) ____________________Phone:____________Relationship:____________

(2) ____________________Phone:____________Relationship:____________

I understand that should I or designated persons not be available, School personnel will contact Emergency Medical Services for care at my expense.

Date: ____________ Parent (Guardian) Signature: ____________________

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MEDICAL AUTHORIZATION OF CARE AFTER INSECT STING

Student: ____________________School: ____________________

□ Oral Benadryl dose ____________________.

□ Epi-Pen Jr. (0.15cc) to be given immediately by trained school staff.

□ Epi-Pen Jr. (0.3cc) to be given immediately by trained school staff.

□ Student may carry and self-administer Epi-Pen (Applies to Middle School and High School students. Elementary schools store med in clinic).

Follow-Up Care:____________________

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Date: ____________________ Dr. Signature & Phone #: ____________________