Individualized Care Plan for Child with Insect Sting Allergy

Student's Name: _____ **DOB:** _____ **Effective Date:** _____

Dear Parent/Guardian:

The following information is requested for students known to have an allergic reaction to **bee stings** or **other insect stings** in order for Wilson Child Care and Early Learning Programs staff to provide your child with the necessary immediate medical care. Please have your child's **physician** complete, sign, and date this form, have a parent/guardian sign and date this form, and return it to the school nurse ***as soon as possible.***

Querido padre/encargado:

La siguiente información es requerida para estudiantes que tienen una reacción alérgica a **picaduras de abejas u otros insectos** para que el personal de Wilson Child Care and Early Learning Programs le pueda dar el cuidado medico a su niño si fuera necesario. Por favor haga que el **doctor** de su niño complete, firme y ponga la fecha en esta forma. El padre o encargado también debe firmar y poner la fecha en la forma. Por favor devuélvala a la enfermera ***lo más pronto posible.***

The following is standard school procedure for anyone stung by a bee or other insect:

- ✓ Remove stinger
- ✓ Observe child
- ✓ Apply insect sting kill swab and ice
- ✓ Document event
- ✓ Contact parent/guardian

Please check the status of your child's problem. ***Check all that apply.***

- ❒ My child has begun receiving allergy shots
- ❒ My child has a severe reaction such as difficulty breathing, facial/lip swelling, hives or shock-like symptoms within moments of the sting.

Please check the appropriate procedure to follow. ***Check all that apply.***

- ❒ Follow the above routine.
- ❒ Notify the parent immediately.
- ❒ Administer medications as ordered below by physician.
- ❒ Administer Epi-Pen as ordered below by physician.

Physician Orders: _____
_____
_____

_____ _____
Physician Signature **Date**

If your child needs medication in school, an additional Medication Administration Form must be completed, signed, and dated by the parent/guardian and the child's physician. The parent/guardian must provide all medication. All medication must be in original, labeled container.

If an Epi-Pen or any other medication is administered, 911 will be called and the child will be transported to the hospital.

_____ _____
Parent/Guardian Signature **Date**

Si su niño necesita tomar medicina en la escuela, tendrá que completar una forma adicional (Administración de Medicinas). Esta forma tendrá que ser firmada por usted y también por el doctor del niño. El padre/encargado tendrá que proveer la medicina. Todas las medicinas deben estar en el recipiente original y deben estar marcadas.

Si un Epi-Pen u otra medicina son administrados, llamaremos al 911 y el niño será transportado al hospital

_____ _____
Firma del padre/encargado **Fecha**

OVER □

I hereby acknowledge that I have reviewed the above Individualized Care Plan, have received applicable training, have been provided the opportunity to ask questions, and fully understand the above Individualized Care Plan.

_____	_____
Teacher/Designee Signature	**Date**
_____	_____
Head Start Health/Nutrition Specialist Signature	**Date**