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**Kenneth Connor**
Therapeutic Day Program
Program Administrator

**Kirsten Grady**
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**Stacy Murphy**
Therapeutic Day Program
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**Margo Sheldon**
Transition Learning Center/RISE
Program Administrator

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

Student's Name: _____ DOB: _____

Address: _____ Tel #: _____

Physician: _____ Phys. Tel#: _____

Does this child have Asthma? Yes _____ No _____

Specific Allergy: _____

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

_____ Observe student for signs of anaphylaxis x 2 hours (see below)

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

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

_____ Administer **Benadryl** _____ mg Liquid Tablets

_____ Administer _____

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

IF REACTION OCCURS, PLEASE NOTIFY THIS OFFICE: 203-365-8864

1. Is this a controlled drug? Yes _____ No _____
2. Medication shall be administered from _____ (Date) to _____ (Date)
3. Relevant side effects to be observed: _____
4. Please allow student to self-administer medication (must meet the guidelines of self-medication assessment) _____

Physician's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

**SYMPTOMS OF ANAPHYLAXIS**

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