

KINGSTON ELEMENTARY SCHOOL
SILVER LAKE REGIONAL SCHOOL DISTRICT
INSECT STING ALLERGY SEVERE FOOD ALLERGY

Date _____

Dear Parent/Guardian of _____,

You have indicated to us at some point in your child's health record that he/she is **allergic to insect/bee stings or has a severe reaction to certain foods**. Please indicate below what action needs to be taken if your child is stung or eats a food to which he is allergic during the school day.

Please note that if your child requires an EpiPen or other medication the enclosed forms must be filled out by you and your child's doctor for each school year.

Please return this form and any medication forms to the school nurse as soon as possible!

If my child is stung by _____ the following actions should be taken:
Name / type of insect

If my child eats _____ the following actions should be taken:
name of food to which child is allergic

List the signs and symptoms your child experiences during an allergic reaction:

Date of last known reaction: _____

I give permission for the school nurse to inform appropriate school personnel of this information.

Parent/Guardian Signature _____ Date _____

Telephone Home (_____) _____ Work (_____) _____

Emergency Contact _____ Phone (_____) _____

Physician's Name _____ Phone (_____) _____

KINGSTON ELEMENTARY SCHOOL
SILVER LAKE REGIONAL SCHOOL DISTRICT
FOOD ALLERGY ACTION PLAN

Place
Child's
Picture
Here

Student's
Name _____ D.O.B. _____ Teacher _____

ALLERGY TO: _____

Asthmatic YES* **NO** *Higher risk for severe reaction

◆ **STEP 1: TREATMENT** ◆

Symptoms:

Give Checked Medication:**

To be
determined
by physician
authorizing
treatment

- If a food allergen has been ingested, but *no symptoms*: EpiPen Antihistamine
- Mouth Itching, tingling, or swelling of lips, tongue, mouth EpiPen Antihistamine
- Skin Hives, itchy rash, swelling of the face or extremities EpiPen Antihistamine
- Gut Nausea, abdominal cramps, vomiting, diarrhea EpiPen Antihistamine
- Throat† Tightening of throat, hoarseness, hacking cough EpiPen Antihistamine
- Lung† Shortness of breath, repetitive coughing, wheezing EpiPen Antihistamine
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness EpiPen Antihistamine
- Other† _____ EpiPen Antihistamine
- If reaction is progressing (several of the above areas affected), give EpiPen Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr.

Antihistamine: give _____
Medication/dose/route

Other: give _____
Medication/dose/route

◆ **STEP 2: EMERGENCY CALLS** ◆

1. Call 911 (or Rescue Squad : _____). State that an allergic reaction has been treated and additional epinephrine may be needed)

2. Dr. _____ at _____

3. Emergency Contacts:

Name/Relationship	Phone Number(s)
a. _____	1. _____ 2. _____
b. _____	1. _____ 2. _____
c. _____	1. _____ 2. _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

KINGSTON ELEMENTARY SCHOOL
MASSACHUSETTS UNION NO. 31
and
SILVER LAKE REGIONAL SCHOOL DISTRICT
MEDICATION ORDER AND AUTHORIZATION FORM

Date _____

PHYSICIAN'S ORDER

Name of Student _____ DOB _____

Grade and Teacher _____

Medication _____

Dosage _____

Route _____

Time to be Administered _____

Side Effects _____

Date of Order _____ Discontinuation Date _____

Drug or Food Allergies _____

Physician's Signature _____

Physician's Address and Phone Number _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request and authorize the School Nurse to give my child _____
the medication ordered above by his/her physician.

I also authorize the teacher of my child to dispense his/her medication during any field trips
during the school year.

Parent/Guardian Signature _____ Date _____

Address _____ Phone _____