

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 and 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

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

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

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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\*\*:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>▪ If a food allergen has been ingested, but <i>no symptoms</i>:</li> <li>▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth</li> <li>▪ Skin Hives, itchy rash, swelling of the face or extremities</li> <li>▪ Gut Nausea, abdominal cramps, vomiting, diarrhea</li> <li>▪ Throat† Tightening of throat, hoarseness, hacking cough</li> <li>▪ Lung† Shortness of breath, repetitive coughing, wheezing</li> <li>▪ Heart† Thready pulse, low blood pressure, fainting, pale, blueness</li> <li>▪ Other† _____</li> <li>▪ If reaction is progressing (several of the above areas affected), give</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> EpiPen    <input type="checkbox"/> Antihistamine</li> </ul> |
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To be determined by physician authorizing treatment

*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 \_\_\_\_\_