SOUTH KINGSTOWN SCHOOL DEPARTMENT
Authorization for Prescription Medications to be Taken During School Hours
BEE STING/SEVERE FOOD ALLERGY

STUDENT'S NAME_____

Please indicate one:

☐ **BEE STING**

The following procedure will be followed for the above named student:
1. Remove stinger from skin, if present.
2. Apply ice.
3. Give_____teaspoon(s) BENADRYL (Parent must supply)

PHYSICIAN TO CIRCLE ONE OPTION:

4a. IMMEDIATELY GIVE EPI-PEN after Benadryl, then call "911" and parent

or

4b. WATCH CLOSELY – if any symptoms of body hives, itching, difficulty breathing, or loss of consciousness, then give EPI-PEN, call "911" and parent.

Dose of EPI-PEN to be given (please circle one):

0.15 mg. 0.3 mg.

☐ **FOOD ALLERGY** (Specify allergen):

_____

The following procedure will be followed for the above named student if ingestion or symptoms of allergic reaction occur:
1. Give_____teaspoon(s) BENADRYL (Parent must supply)

PHYSICIAN TO CIRCLE ONE OPTION:

2a. IMMEDIATELY GIVE EPI-PEN after Benadryl and call "911" and parent.

or

2b. WATCH CLOSELY – if any symptoms of difficulty breathing or swallowing, or loss of consciousness, then give EPI-PEN, call "911" and parent.

Dose of EPI-PEN to be given (please circle one)

0.15 mg. ~~.03 mg.~~ .3mg

_____ _____
physician's signature *date*

I am in agreement with the above procedure and will provide the Benadryl and/or EPI-PEN to be kept at school.

_____ _____
parent/guardian signature *date*