Bee Sting Allergy Action Plan

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

Allergy to:_____ **Asthmatic:** Yes* ☐ No ☐ *Higher risk for severe reaction

Place Child's Picture Here

■ STEP 1: TREATMENT ■

Symptoms:	**Give Checked Medication**:** **(to be determined by physician authorizing treatment)
▪ If a bee sting has occurred, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ **Mouth** Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ **Skin** Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ **Gut** Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ **Throat†** Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ **Lung†** Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ **Heart†** Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ **Other†** _____	☐ Epinephrine ☐ Antihistamine
▪ **If reaction is progressing (several of the above areas affected), give:**	☐ Epinephrine ☐ Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one, and see reverse side for instructions)

EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg Adrenaclick™ 0.3mg Adrenaclick™ 0.15 mg

Antihistamine: give (medication/dose/route)_____

Other: give (medication/dose/route)_____

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

■ STEP 2: EMERGENCY CALLS ■

1. **Call 911**. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. _____ Phone Number:_____
3. Parent_____ Phone Number(s):_____
4. Emergency contacts:
   a. Name/Relationship_____ Phone Number:_____
   b. Name/Relationship_____ Phone Number:_____

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

PLEASE REVIEW, SIGN AND RETURN this form to the School Nurse.

*The information above is correct and should be used in the event of an allergic reaction at school.

*I give my permission for a photo to be taken and shared with school personnel interacting with my student.

*The School Nurse may share this Allergy Action Plan with all school personnel interacting with my student.

*The School Nurse may contact the doctor listed above to discuss this information.

*If the student is sent to the emergency department, a follow-up report can be faxed to the School Nurse.

Parent/Guardian Signature:_____ **Date:**_____

Doctor's Signature:_____ **Date:**_____