

BEE STING/INSECT ALLERGY Action Plan

Student's

Name: _____ D.O.B: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes* No * Higher risk for severe reaction



STEP 1: TREATMENT

<u>Symptoms:</u>	Give Checked Medication**:
	<small>** (To be determined by physician authorizing treatment)</small>
• Local reaction at site of bite	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Throat* Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Lung* Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Heart* Weak or thread pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• Other*	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine
• If reaction is progressing (several of the above areas affected), give:	<input type="checkbox"/> Epinephrine <input type="checkbox"/> Antihistamine

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

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen Jr.® Auvi-Q 0.15 mg Auvi-Q 0.3mg

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

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

1. Dr. _____ Phone Number _____

2. Parent _____ Phone Number _____

3. Emergency contacts:
Name/Relationship _____ Phone Number(s) _____

a. _____

b. _____

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

Parent/Guardian's Signature _____ Date _____

Doctor's Signature (Required) _____ Date _____