

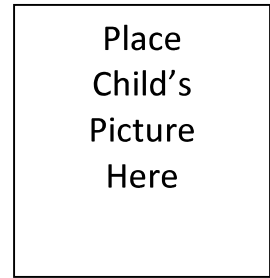
## BEE STING/INSECT ALLERGY Action Plan

Student's

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

Asthmatic Yes\*  No  \* Higher risk for severe reaction



### STEP 1: TREATMENT

<u>Symptoms:</u>	<b>Give Checked Medication**:</b>
• 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

\*\* (To be determined by physician authorizing treatment)

\*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 \_\_\_\_\_