# Bee Sting Allergy Action Plan

Name:_______________________________ D.O.B.__________ Teacher:____________________

Allergy to:______________________________________________________________

Asthma: Yes_____ (higher risk for a severe reaction) No_____

| Any SEVERE SYMPTOMS after suspected or known Ingestion:<br><br>One or more of the following:<br>LUNG: Short of breath, wheeze, repetitive cough<br>HEART: Pale, blue, faint, weak pulse, dizzy, confused<br>THROAT: Tight, hoarse, trouble breathing/swallowing<br>MOUTH: Obstructive swelling (tongue and/or lips)<br>SKIN: Many hives over body<br><br>Or **combination** of symptoms from different body areas:<br>SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)<br>GUT: Vomiting, crampy pain | **1. INJECT EPINEPHRINE IMMEDIATELY**<br>**2. Call 911**<br>**3. Begin monitoring (see box below**<br>**4. Give additional medications***<br><br>**-Antihistamine**<br>**-Inhaler (bronchodilator) if has asthma**<br>***Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.** |
|---|---|
| **MILD SYMPTOMS ONLY:**<br><br>SKIN: Redness and swelling at the site. | 1. Wash site and remove stinger.<br>2. Make a paste with meat tenderizer and cover w/ band-aid.<br>3. Apply ice.<br>4. Notify parent.<br>5. Monitor for changes. |

LICENSED PRESCRIBER SECTION

## Medications/Doses

Epinephrine (brand and dose):_____________________________________________

Antihistamine (brand and dose):___________________________________________

Other (e.g., inhaler-bronchodilator if asthmatic):___________________________

___ **If checked, give epinephrine immediately for ANY symptoms of an allergic reaction.**

___ **If checked, give epinephrine immediately if stung, even if no symptoms are noted.**

## Monitoring

***Stay with student; alert healthcare professional and parent.*** Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student on back with legs raised. Treat student even if parents cannot be reached. See back for auto-injection technique.

_____________________________ _______________ ____________

Licensed prescriber signature Phone Date

**TURN FORM OVER**

I certify that I have completed a (yellow) Emergency Medical Authorization Form.

I have completed the School Bee Sting Record and will supply the school with medication necessary for treatment of my child's bee sting allergy.

______________________________________________ ________________

Parent/Guardian Signature Date

The information requested is confidential and will only be shared with the appropriate personnel (i.e., principal, teachers, secretary and food service). The information that you relate to us will enable us to take immediate and appropriate action in caring for your child. It is now permissible by Ohio State Law for students to carry and use an EpiPen with the written authorization of the prescriber and the parent/guardian. A backup EpiPen is required for the clinic.

## Contacts

**Parent/Guardian**___________________________

**Phone**_____________________________

**Parent/Guardian**___________________________

**Phone**_____________________________

**Physician**_________________________________

**Phone**_____________________________

**Other Emergency Contacts:**
**Name/Relationship**_______________________

**Phone**_____________________________

**Name/Relationship**_______________________

**Phone**_____________________________

**School Staff Section**

**Medication given**____________________**date**_______**time**____

**Given by**_________________________________________

**Medication given**____________________**date**_______**time**____

**Given by**_________________________________________

**Medication given**____________________**date**_______**time**____

**Given by**_________________________________________