Place Child's Picture Here

Antietam School District
Anaphylactic Bee Sting Allergy Action Plan

Student's Name:_____D.O.B:_____Teacher:_____
ALLERGY TO:_____

Asthmatic: Yes No (circle one) *Higher risk for severe reaction

911 MUST BE CALLED IF THE EPI PEN IS ADMINISTERED.

STEP 1: TREATMENT

To be determined by physician authorizing treatment

Symptoms:	Give Checked Medication :
• If stung by bee, and no symptoms:	☐ EpiPen ☐ Antihistamine
• Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen ☐ Antihistamine
• Skin Hives, itchy rash, swelling of the face or extremities	☐ EpiPen ☐ Antihistamine
• Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen ☐ Antihistamine
• Throat = Tightening of throat, hoarseness, hacking cough	☐ EpiPen ☐ Antihistamine
• Lung = Shortness of breath, repetitive coughing, wheezing	☐ EpiPen ☐ Antihistamine
• Heart = Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen ☐ Antihistamine
• Other = _____	☐ EpiPen ☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give	☐ EpiPen ☐ Antihistamine

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

- May administer second dose of twinject after _____ mins. if symptoms return. YES NO (circle one)

DOSAGE: Kept in nurse's office: Yes___ No___ Kept in Backpack: Yes___ No___

Epinephrine: inject intramuscularly (circle one) EpiPen /EpiPen Jr. /Twinject 0.3/ Twinject 0.15

Antihistamine: give _____ Exp. Date_____
medication/dose/route

Other: give_____ Exp. Date_____
medication/dose/route

STUDENT HAS BEEN INSTRUCTED TO SELF-INJECT Yes____ No____
Who instructed_____ Date_____

STEP 2: EMERGENCY CALLS

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

3. Emergency contacts: Name/Relationships Phone Number(s)
a. _____ 1.)_____ 2.) _____
b. _____ 1.)_____ 2.) _____
c. _____ 1.)_____ 2.) _____
Parent Requests_____

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

Doctor's Signature_____ Date_____
(Required)

Parent/Guardian Signature (Required)_____Date_____