BEE STING

ALLERGY ACTION PLAN

Place Child's Picture Here

Student's Name_____ D.O.B._____ Teachers: _____

Allergy To: _____

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

STEP 1: Treatment

Symptoms		Give Checked Medication** (TO BE DEDERMINTED BY PHYSICIAN AUTHORIZING TREATMENT)
• If a bee sting has occurred, but no symptoms		☐ Epinephrine ☐ Antihistamine
• Site of sting	Swelling, redness, itching	☐ Epinephrine ☐ Antihistamine
• Skin	Itching, tingling, or swelling of lips, tongue, mouth	☐ 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†	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
• Mouth	If a bee sting has occurred, but no sumptoms	☐ Epinephrine ☐ Antihistamine
• If reaction is progressing (several of the above areas affected), give		☐ Epinephrine ☐ Antihistamine

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

DOSAGE

Antihistamine: give _____
MEDICATION / DOSE/ ROUTE

Other: give _____
MEDICATION / DOSE/ ROUTE

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 / Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

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

Parent / Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(REQUIRED)