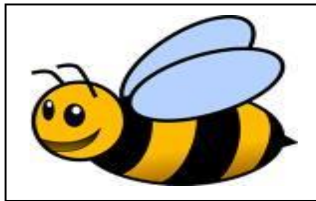

# Bee Sting

## Allergy Action Plan

Place Child's Picture Here

**Student's Name: _______________________ D.O.B._________ Teacher: ___________**
**Allergy to: _______________________________________________________________**

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

## Step 1: Treatment

### Symptoms

### Give Checked Medication**

(To be determined by physician authorizing treatment)

| Symptoms | | Medication | | |
|---|---|---|---|---|
| •If a bee sting has occurred, but no symptoms | | __ Epinephrine | __ Antihistamine | __None |
| •Site of sting | Swelling, redness, itching | __ Epinephrine | __ Antihistamine | __None |
| •Skin | Itching, tingling or swelling of lips, tongue, mouth | __ Epinephrine | __ Antihistamine | __None |
| •Gut | Nausea, abdominal cramps, vomiting, diarrhea | __ Epinephrine | __ Antihistamine | __None |
| •Throat† | Tightening of throat, hoarseness, coughing | __ Epinephrine | __ Antihistamine | __None |
| •Lung† | Shortness of breath, repetitive coughing, wheezing | __ Epinephrine | __ Antihistamine | __None |
| •Heart† | Thready pulse, low blood pressure, fainting, pale, blueness | __ Epinephrine | __ Antihistamine | __None |
| •Mouth | If a bee sting has occurred, but no symptoms | __ Epinephrine | __ Antihistamine | __None |
| •If reaction is progressing (several of the above areas affected) give, | | __ Epinephrine | __ Antihistamine | __None |

The severity if the 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 PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian Signature: _____________________________________________________ Date: ______________

Doctor Signature: _____________________________________________________________ Date: ______________
(Required)