Bee Sting Allergy Action Plan

Allergy Action Plan must be updated / received annually.

Student's Name: ______________________________ D.O.B:____________ Grade/Teacher:________________

Bus Route/Driver: ____________________________

ALLERGY TO: ____

Asthmatic: Yes*____________ No___________ *Higher risk for severe reaction.

STEP 1: Treatment

Symptoms		**Give Checked Medication** (To be determined by Physician Authorizing Treatment)	
●If a bee sting occurs, but no symptoms		□ Epinephrine	□ Antihistamine
●Nose/Eyes:	Itching, sneezing, congestion, runny nose, tearing	□ Epinephrine	□ Antihistamine
●Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	□ Epinephrine	□ Antihistamine
●Skin:	Hives, itchy rash, swelling of face or extremities	□ Epinephrine	□ Antihistamine
●Gut:	Nausea, abdominal cramps, vomiting diarrhea	□ Epinephrine	□ Antihistamine
●Throat*:	Tightening of throat, hoarseness, difficulty swallowing/speaking	□ Epinephrine	□ Antihistamine
●Lung*:	Shortness of breath, wheezing, repetitive coughing, chest tightness	□ Epinephrine	□ Antihistamine
●Heart*:	Thready pulse, low blood pressure, pale fainting, blue	□ Epinephrine	□ Antihistamine
●If reaction is progressing (several of the above areas affected), give:		□ Epinephrine	□ Antihistamine

*Potentially life-threatening, the severity of symptoms can change quickly, Asthma = higher risk for severe reaction

Dosage

Epinephrine: Inject intramuscularly (outer thigh) (circle one): See reverse side for instructions.

EpiPen® EpiPen ® Jr. Twinject™ 0.3mg Twinject™ 0.15mg

A second dose of epinephrine may be administered if no improvement of symptoms occurs within 15 minutes. Yes______ No____

Antihistamine: give: medication/dose/route:____

Other: give: medication/dose/route: ____

Step 2: Emergency Calls

1. Call **911 any time EPI is given. State that an allergic reaction has been treated, and additional epinephrine may be needed. Hospital Choice:** ____________________________
2. Emergency contact: Name/Number/Relationship to student:
   A.____________________________/______________________________/____________________
   B.____________________________/______________________________/____________________
3. Contact Dr. ______________________________ Phone: ______________________________

EVEN IF PARENT/GUARDIAN CAN'T BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY

Doctor's Signature: ____ Date: ____________________
(Required)

Medication Consent:
I hereby give permission to designated, trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instruction of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.

I hereby give permission to school personnel to notify other appropriate school personnel and classroom teachers of student condition and medication administration.

I further agree to hold Amelia County Public Schools and the employee(s) who is/are administering the medication harmless in any or all claims arising from the administration of this medication at school.

I agree to notify the school at the termination of this request or when any change in the above order is necessary.

Parent / Guardian Signature: ______________________________ Date: ________________