Allergy Action Plan (Bee Sting)

School Year 20____ to 20____

Name _____ DOB _____/_____/_____

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

Emergency Plan (to be completed by physician)

Treatment

Symptoms		Give Checked Medication
■ If a bee sting has occurred, but *no symptoms*:		☐ EpiPen ☐ Antihistamine
■ Site of Sting	Swelling, redness, itching	☐ EpiPen ☐ Antihistamine
■ Skin	Itching, tingling or swelling of lips, tongue, mouth	☐ 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 BP, 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

Dosage

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr (see reverse side for instructions)
Dose: _____mg

Antihistamine: Give _____
medication/dose/route

Other: Give _____
medication/dose/route

Emergency Calls

1. **Call 911.** State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Parent/Guardian _____ Home Phone_____
   Work Phone _____ Cell Phone_____
3. Dr. _____ at _____
4. Emergency Contact (if parent cannot be reached) _____
   Phone_____

Parent/Guardian Signature _____

Physician Signature _____

Physician Printed Name _____ Address_____