



Phone: 704-237-5333 Fax: 704-237-5398

## BEE STING

### ALLERGY ACTION PLAN

This record is to be completed by parents/guardians in consultation with their child's physician. Please check the appropriate box and print your answers clearly in the blank spaces where indicated. The information on this Plan is confidential. All staff that care for your child will have access to this information. The school will only disclose this information to others with your consent. Please contact the school at any time if you need to update this Plan or you have any questions regarding the management of bee sting allergies at school. It is the responsibility of the parent/guardian to assure the Bee Sting Allergy Action Plan is in place for their child and the school is provided with adequate medication as stated in the Guidelines for Management of Students with Severe Allergies in the Pine Lake Preparatory Handbook.

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Grade \_\_\_\_\_ Academic Partner \_\_\_\_\_

**ALLERGIC TO:** \_\_\_\_\_

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

### STEP ONE: RECOMMENDED TREATMENT

**Symptoms:**

**Give Checked Medication\*\*:**

(\*\*To be determined by physician authorizing treatment)

- |  |  |                                 |  |
|--|--|---------------------------------|--|
| ● If a bee sting has occurred, but <i>no symptoms</i>                      |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Site of sting    Swelling, redness, itching                              |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Mouth            Itching, tingling, swelling of tongue or mouth          |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Skin              Hives, itchy rash, swelling of the face or extremities |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Gut                Nausea, abdominal cramps, vomiting, diarrhea          |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Throat+          Tightening of throat, hoarseness, hacking cough         |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Lung+            Shortness of breath, repetitive coughing, wheezing      |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Heart+           Weak/thread pulse, low blood pressure, fainting, pallor |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● Other+           _____   |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |
| ● If reaction is progressing (several of above areas affected), give       |  | <input type="checkbox"/> EpiPen | <input type="checkbox"/> Antihistamine |

The severity of symptoms can change quickly + Potentially Life-threatening.

**Dosage:**

**Epinephrine:** Inject intramuscularly (circle one)      EpiPen      EpiPen Jr.      (see attached for instruction)

**Antihistamine (Medication/Dose/Route/Frequency):** Give \_\_\_\_\_

**Other (Medication/Dose/Route/Frequency):** Give \_\_\_\_\_

**STEP TWO: EMERGENCY CALLS**

**Nurse Ext: #5333/ cell # 704-237-5333**

1. **Call 911.** State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at phone # \_\_\_\_\_

3. Emergency Contacts:

Name/Relationship:

Phone Number(s)

a. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_

b. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_

c. \_\_\_\_\_ 1) \_\_\_\_\_ 2) \_\_\_\_\_

**IN THE EVENT THAT A PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO  
MEDICATE OR TAKE CHILD TO MEDICAL FACILITY**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature (required) \_\_\_\_\_ Date \_\_\_\_\_