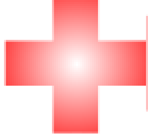
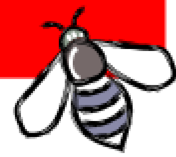




Sample

BEE STING ALLERGY

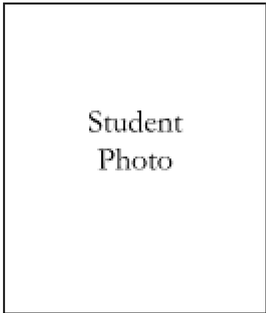
Student: Grade: School Contact: DOB:

Asthmatic: ❑ Yes ❑ No (increased risk for severe reaction) Severity of reaction(s):

Mother: M Home #: M Work #: M Cell #:

Father: F Home #: F Work #: F Cell #:

Emergency Contact: Relationship: _ Phone:



SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is give immediately.

STAFF MEMBERS INSTRUCTED: ❑ Classroom Teacher(s) ❑ Special Area Teacher(s) ❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ❑ with symptoms ❑ without waiting for symptoms
Benadryl ordered: ❑ Yes ❑ No Give Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ❑ Yes ❑ No Special instructions:

IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.

Preferred Hospital if transported:

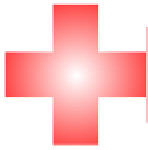
Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ❑ Medication available on bus ❑ Medication NOT available on bus ❑ Does not ride bus

Special instructions:

This plan is in effect for the current school year and summer school as needed.

Revised 1/08



Sample

Healthcare Provider: Phone:

Written by: Date:

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff:

This plan is in effect for the current school year and summer school as needed.