



Columbia Borough School District Bee Sting Action Plan

Student's Information:

Name: _____ D.O.B. ____/____/____
Grade: _____ Teacher: _____

Emergency Information

Parents/Guardian's names: _____
Mother's phone (C): _____ Father's phone (C): _____
Home: _____
Physician's Name: _____ Phone: _____

In case of emergency, contact:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

Bee Sting Action Plan

The following are possible signs of a severe reaction and an emergency:

- Difficulty breathing, repetitive cough, and/or wheezing
- Itching and swelling of the lips, tongue, and/or mouth
- Itching and/or sense of tightness in the throat, hoarseness, and a hacking cough
- Hives, itchy rash, and/or swelling of the face and extremities
- Nausea, abdominal cramps, vomiting, and/or diarrhea
- Weak pulse, passing out

The severity of symptoms can quickly change. *All the above symptoms can potentially progress to a life-threatening situation.

These signs indicate the need for emergency medical care. The steps that should be taken are:

- Give prescribed medication _____ (name/dose/route)

IMMEDIATELY

- Activate EMS (ask for advanced life support)
- Call parent/guardian or physician

Action for Minor reaction

1. If the only symptoms are: _____ give
_____ (medication/dose /route).

If symptoms worsen after the above treatment, follow the steps for a major reaction.

Current Medications: *(completed by physician)*

Medication	Dosage	Time	Administer at School?

Parent's signature: _____ Date: ____/____/____
Physician's signature: _____ Date: ____/____/____