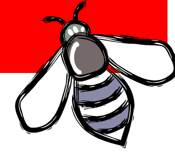
Emergency Care Plan



BEE STING ALLERGY

Student: ______________________________ Grade: ________ DOB: ______________

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

Parent 1: ______________________ Home #: ________ Work #: ________ Cell #: _______

Parent 2: ______________________ Home #: ________ Work #: ________ Cell #: _______

Emergency Contact: ______________________ Relationship: __________ Phone: ______________

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

- **MOUTH** Itching and 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.

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 ___ **Dosage Schedule**: ______________________________
*self-carry Yes ___ No ___
____

Epinephrine ordered: Yes ___ No ___ **Dosage Schedule**: ______________________________
*self-carry Yes ___ No ___
____

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. Call school nurse / parent if off school grounds.

*I attest that this student has demonstrated to me that they can self-administer this medication.

Physician's Signature______________________________ Date: ____________

Physician's Name (please print) ______________________________ Phone: ____________

Parent/Guardian Signature: ______________________________ Date: ____________

** This plan will be shared with pertinent staff on an as need to know basis and is in effect for the current school year and summer school if needed.

This plan is in effect for the current school year and summer school as needed. Revised 11/22