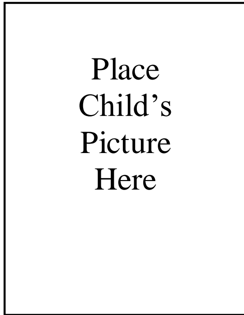
Insect Allergy Action Plan



Student's Name: ______________________________ **D.O.B.:** ____________ **Teacher:** _____________________

ALLERGY TO: ____

Asthmatic? Yes* ☐ **NO** ☐ *** Higher risk for severe reaction**

◆ STEP 1: TREATMENT ◆

Symptoms:	**Give Checked Medication**:** (To be determined by physician authorizing treatment)	
▪ If has been stung/bitten, but no symptoms:	☐ Epinephrine	☐ Antihistamine
▪ Mouth – Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
▪ Skin – Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
▪ Gut – Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
▪ Throat † – Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
▪ Lung † – Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
▪ Heart † – Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
▪ Other † – ______________________________	☐ Epinephrine	☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give	☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. † Potentially life-threatening.

DOSAGE:

Epinephrine: inject intramuscularly (Circle one) **EpiPen® 0.3mg** **EpiPen® Jr. 0.15mg**
(see reverse side for instructions)

Antihistamine: give ____
Medication/dose/route

Other: give ____
Medication/dose/route

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: __________________) . State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. ______________________________ at ______________________________
   Physician's Name Printed — Doctor's phone number
3. Emergency Contacts:

Name/Relationship	Phone Number(s)	
a. ______________________	1.)__________________	2.) __________________
b. ______________________	1.)__________________	2.) __________________
c. ______________________	1.)__________________	2.) __________________

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HEISTATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY:

Parent/Guardian Signature ______________________________________ Date: __________________

Doctor's Signature ______________________________________ Date: __________________