Visitation School

Bee Sting Action Plan

Place Your Child's Photo Here

Student's Name: _____ Date of Birth: _____

◆ Step 1: TREATMENT ◆

(Step 1 is to be completed by your child's physician)

Asthmatic: ❑ Yes* ❑ No *Higher risk for severe reaction

ALLERGIC TO: _____

Body Part	Symptoms	Give Checked Medication (to be determined by physician authorizing treatment)	
Mouth	Itching, tingling, or swelling of the lips, tongue, mouth	❑ EpiPen	❑ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	❑ EpiPen	❑ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	❑ EpiPen	❑ Antihistamine
Throat※	Tightening of the throat, hoarseness, hacking cough	❑ EpiPen	❑ Antihistamine
Lung※	Shortness of breath, repetitive coughing, wheezing	❑ EpiPen	❑ Antihistamine
Heart※	Thready pulse, low blood pressure, fainting, pale, blueness	❑ EpiPen	❑ Antihistamine
Other※	_____	❑ EpiPen	❑ Antihistamine
If reaction is progressing (several of the above areas are affected), give:		❑ EpiPen	❑ Antihistamine

The severity of symptoms can quickly change.

※ **Potentially life-threatening**

DOSAGE:

Epinephrine: inject intramuscularly **(circle one)**: EpiPen EpiPen Jr.

Antihistamine: give _____
medication / dose / route

Other: give _____
medication / dose / route

_____ _____ (_____)_____

Licensed Prescriber's Signature **Date** **Phone Number**

◆ Step 2: EMERGENCY CALLS ◆

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

2. Call Dr. _____ at (_____)_____
name phone number

3. Call emergency contacts:

Name	Relation	Phone Number #1	Phone Number #2

*****EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!*****

_____ _____ (_____)_____

Parent/Guardian Signature Date Phone Number

Updated Feb. 2023

Visitation School

EpiPen Form

Visitation requires all students, who are prescribed an Epi-Pen by their physician, to supply the Visitation Health Office with a back- up Epi-Pen. This Epi-Pen is in addition to the Epi-Pen that they must carry with them throughout the school day.

Student Name:_____Date of Birth:_____Grade : _____

Please indicate specifically how you would like us to administer the EpiPen
(Form to be completed by your child's physician.)

The EpiPen is to be used after exposure to the following allergens:

_____

_____

Administer the EpiPen as follows (**check one**):

- ❑ Immediately after exposure to the above listed allergens.
- ❑ Only if the following symptoms are exhibited:

_____

_____

_____

Whenever an EpiPen is administered, 911 is called immediately. If you have any additional instructions, please list them:

_____

_____

_____

_____ _____ (_____)_____

MD/NP/PA Signature **Date** **Phone Number**

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