



Bullard Independent School District  
**Insect Bite/Sting Allergy Action Plan**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Teacher: \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

Asthmatic:  Yes\*  No \*Increased risk for severe reaction

**◆STEP 1: TREATMENT◆**

**Symptoms:**

**Give Checked Medication••:**

**\*\*\*\* To be determined by a physician authorizing treatment\*\*\*\***

- If stung/bitten by insect 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. \*

**\*\*\*\*To Be determined by authorizing physician \*\*\*\***

**DOSAGE**

**Epinephrine:** inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

**◆STEP 2: EMERGENCY CALLS◆**

1. Call 911. State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Dr. \_\_\_\_\_ Phone Number \_\_\_\_\_
3. Parent/Guardian: \_\_\_\_\_ Phone Number(s) \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

(Required)

