

The St. Paul's Schools – Bee Sting Allergy Action Plan

Student's Name: _____ Birthdate: _____ Grade: _____

Emergency Contact Name: _____ Phone: _____

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WHEN IN DOUBT, GIVE EPINEPHRINE AND CALL 911!

ALLERGY: _____

SYMPTOMS:

Give Checked Medication

- | | | |
|---|---------------------------------|-----------------------------------|
| • If bee sting has occurred, but no symptoms: | ☐ EpiPen | ☐ Benadryl |
| • Mouth – itching, tingling, or lip swelling or swelling of the tongue, mouth | ☐ EpiPen | ☐ Benadryl |
| • Skin – hives, itchy rash, swelling of the face or extremities | ☐ EpiPen | ☐ Benadryl |
| • Gut – nausea, abdominal cramps, vomiting, diarrhea | ☐ EpiPen | ☐ Benadryl |
| • Throat – itching, swelling, or tightening of the throat, hoarseness | ☐ EpiPen | ☐ Benadryl |
| • Lung – shortness of breath, repetitive coughing, wheezing | ☐ EpiPen | ☐ Benadryl |
| • Heart - thready pulse, fainting, lightheaded, pale, blueness | ☐ EpiPen | ☐ Benadryl |
| • Other _____ | ☐ EpiPen | ☐ Benadryl |
| • If the reaction is progressing (or if 2 or more above areas are affected), give: | ☐ EpiPen | ☐ Benadryl |

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

DOSAGE:

Epinephrine: ☐ EpiPen or ☐ EpiPen Jr. ☐ Other _____ Administer in the lateral thigh

Benadryl: Give _____

ALLERGIC REACTION TIME SCHEDULE: In case of accidental ingestion of food with known or unknown allergens, please indicate length of time for observation by school nurse for signs of an allergic reaction. Please note that in a school setting, monitoring a student for greater than 30 minutes becomes the parents' responsibility.

☐ 0-30 minutes ☐ 30-60 minutes ☐ 60 minutes or longer

Prescribing Physician's Signature _____ Date _____

(Parent signature not acceptable)