Bee Sting Allergy Action Plan

Student Name: _____D.O.B _____Grade: ___
Asthmatic: _____Yes _____No

Step 1: TREATMENT (Give Checked Medication)

Symptoms:

• **None**	**_____Epinephrine**	**_____Antihistamine**
• **Mouth –itching, tingling, or swelling**	**_____Epinephrine**	**_____Antihistamine**
• **Skin –hives, rash, swelling**	**_____Epinephrine**	**_____Antihistamine**
• **Throat –cough, hoarseness, tightening**	**_____Epinephrine**	**_____Antihistamine**
• **Lung –shortness of breath, wheezing**	**_____Epinephrine**	**_____Antihistamine**
• **Heart –weak pulse, low blood pressure**	**_____Epinephrine**	**_____Antihistamine**
• **Other _____**	**_____Epinephrine**	**_____Antihistamine**
• **If reaction is progressing give:**	**_____Epinephrine**	**_____Antihistamine**

DOSAGE

Epinephrine: inject IM (circle one): EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15

Antihistamine: give _____
Medication/dosage/route

Other: give _____
Medication/dosage/route

Step 2: EMERGENCY CALLS

1. **Call 911. State Allergic reaction has been treated and additional epinephrine may be needed.**
2. **Dr. _____ Phone number _____**
3. **Parent _____ Phone number _____**
4. **Emergency Contacts:**
   a. **_____**
   Name/relationship/phone number

   b. **_____**
   Name/relationship/phone number

Parent/Guardian Signature: _____ Date _____

Doctor's Signature: _____Date _____
(required)

****STUDENT WILL BE TRANSPORTED TO MEDICAL FACILITY EVEN IF PARENT CANNOT BE REACHED**