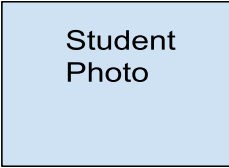




Berea City School District  
EXCELLENCE • INTEGRITY • PURPOSE

Serving Berea, Brook Park and Middleburg Heights



### Insect Allergy Action Plan

<b>Student's Name:</b>	<b>School/Grade:</b>
<b>Date of Birth:</b>	<b>Contact Teacher:</b>
<b>Parent/Guardian Name:</b>	<b>Phone (Family):</b>
<b>Address:</b>	
<b>Physician:</b>	<b>RN:</b>
<b>Emergency Number:</b>	

Allergy to: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs.      Asthma: \_\_\_\_\_ Yes (higher risk for a severe reaction)      \_\_\_\_\_ No

The student is capable of possessing and using the auto injector appropriately per MD orders.

The student has been trained on the proper use of auto injector.

\* If either of the above boxes are **NOT** checked student may **NOT** carry auto injector.

\*\*One epinephrine auto-injector is **REQUIRED** to be stored in the school clinic.

**1. Any SEVERE SYMPTOMS after suspected sting:**

**One or more of the following:**

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body
- Or **combination** of symptoms from different body areas:
- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, diarrhea, crampy pain

**Treatment:**

1. INJECT EPINEPHRINE IMMEDIATELY
2. Call 911
3. Begin Monitoring
4. Give additional medications (if ordered)
  - a. Antihistamine
  - b. Inhaler (bronchodilator) if asthma

**2. MILD SYMPTOMS ONLY:**

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort

**Treatment:**

1. GIVE ANTIHISTAMINE
- 2.. If symptoms progress (see above), USE EPINEPHRINE
3. Begin monitoring

**Medications/Doses**

Epinephrine (brand and dose): \_\_\_\_\_

Antihistamine (brand and dose): \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthmatic): \_\_\_\_\_

*This plan is subject to change but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff and transportation that are involved with student's school day.*

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if the health status of the student listed above changes, we change physicians, or there is a change or cancellation of the physician's orders.

Parent/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Registered Nurse \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL REVIEW**

I have reviewed the attached Action Plan for \_\_\_\_\_, AND:

\_\_\_\_\_ I approve the Action Plan as written.

\_\_\_\_\_ I approve the Action Plan with the attached amendments.

\_\_\_\_\_ I do not approve of the Action Plan as written, and substitute orders are attached.

Physician \_\_\_\_\_ Date \_\_\_\_\_

**Other Recommendations**

Copies to:  Board Office  Bus Garage  Teacher  Other \_\_\_\_\_