



Emergency Care Plan



Sample

BEE STING ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthmatic: ☐ Yes ☐ No (increased risk for severe reaction) Severity of reaction(s): _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- **MOUTH** Itching & swelling of lips, tongue or mouth
- **THROAT** Itching, tightness in throat, hoarseness, cough
- **SKIN** Hives, itchy rash, swelling of face and extremities
- **STOMACH** Nausea, abdominal cramps, vomiting, diarrhea
- **LUNG** Shortness of breath, repetitive cough, wheezing
- **HEART** "Thready pulse", "passing out"

**The severity of symptoms can change quickly –
It is important that treatment is given immediately.**

Student
Photo

STAFF MEMBERS INSTRUCTED:

- ☐ Administration ☐ Classroom Teacher(s) ☐ Special Area Teacher(s)
☐ Support Staff ☐ Transportation Staff

TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.

Treatment should be initiated ☐ with symptoms ☐ without waiting for symptoms

Benadryl ordered: ☐ Yes ☐ No Give _____ Benadryl per provider's orders

Call school nurse. Call parent/guardian if off school grounds.

Epinephrine ordered: ☐ Yes ☐ No Special instructions: _____

**IF ANY SYMPTOMS BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING ARE PRESENT
AND EPINEPHRINE IS ORDERED, GIVE EPINEPHRINE IMMEDIATELY AND CALL 911.**

Preferred Hospital if transported: _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or have an increased heart rate. This is a normal response. Students receiving epinephrine should be transported to the hospital by ambulance. A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present.

Transportation Plan: ☐ Medication available on bus ☐ Medication NOT available on bus ☐ Does not ride bus

Special instructions: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed.

Revised 1/08