

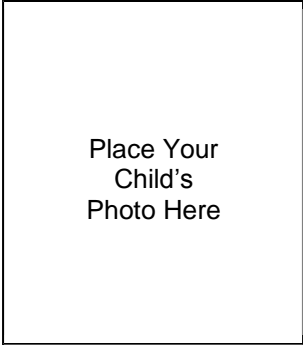


Visitation School

Health Office

Bee Sting Action Plan

Student's Name: _____ Date of Birth: _____



◆ Step 1: TREATMENT ◆

(Step 1 is to be completed by your child's physician)

Asthmatic: Yes* No *Higher risk for severe reaction

ALLERGIC TO: _____

Body Part	Symptoms	Give Checked Medication	
		(to be determined by physician authorizing treatment)	
Mouth	Itching, tingling, or swelling of the lips, tongue, mouth	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
Throat*	Tightening of the throat, hoarseness, hacking cough	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
Other*	_____	<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine
If reaction is progressing (several of the above areas are affected), give:		<input type="checkbox"/> EpiPen	<input type="checkbox"/> Antihistamine

The severity of symptoms can quickly change.

* Potentially life-threatening

DOSAGE:

Epinephrine: inject intramuscularly (**circle one**): EpiPen EpiPen Jr.

Antihistamine: give _____
medication / dose / route

Other: give _____
medication / dose / route

Licensed Prescriber's Signature **Date** **() Phone Number**

◆ Step 2: EMERGENCY CALLS ◆

1. Call 911. State that an allergic reaction has been treated and additional epinephrine may be needed.

2. Call Dr. _____ at (_____) _____
name phone number

3. Call emergency contacts:

Name	Relation	Phone Number #1	Phone Number #2

*****EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!*****

Parent/Guardian Signature **Date** **() Phone Number**



Visitation School

Health Office

EpiPen Form

Visitation requires all students, who are prescribed an Epi-Pen by their physician, to supply the Visitation Health Office with a back-up Epi-Pen. This Epi-Pen is in addition to the Epi-Pen that they must carry with them throughout the school day.

Student Name: _____ Date of Birth: _____ Grade: _____

Please indicate specifically how you would like us to administer the EpiPen
(Form to be completed by your child's physician.)

The EpiPen is to be used after exposure to the following allergens:

Administer the EpiPen as follows (check one):

- Immediately after exposure to the above listed allergens.
- Only if the following symptoms are exhibited:

Whenever an EpiPen is administered, 911 is called immediately. If you have any additional instructions, please list them:

MD/NP/PA Signature

Date

(_____)_____
Phone Number