

BEE STING ALLERGY TREATMENT PLAN

STUDENT'S NAME _____ D.O.B. _____

ASTHMATIC YES* ___ NO ___ *High risk for severe reaction

SIGNS OF ALLERGIC REACTION

Systems:

Mouth
Throat*
Skin
Lung*
Heart*

Symptoms:

itching & swelling of the lips, tongue or mouth
itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
hives, itchy rash and/or swelling about the face or extremities
shortness of breath, repetitive coughing and/or wheezing
“thready” pulse, “passing out”

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

ACTION FOR MINOR REACTION

1. If only symptom(s) are: _____
give _____

Then call:

2. Mother _____, Father _____, or emergency contact.

3. Doctor _____ at _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. If stung and/or symptom(s) are: _____,

Give _____ IMMEDIATELY!

MEDICATION/DOSE/ROUTE

THEN CALL:

2. Rescue Squad (ask for advanced life support)

3. Parents

4. Doctor

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature _____ Date _____

Doctor's Signature _____ Date _____

Doctor's Stamp

ANAPHYLAXIS INDIVIDUAL EMERGENCY CARE PLAN

Student's Name _____ DOB: _____ Teacher: _____

ALLERGY TO: _____ Asthmatic: Yes ___ No ___

Parent/Guardian Telephone Numbers:

Name/Relationship	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

This reaction **could** ___ **could not** ___ be described as anaphylactic. Presenting symptoms include:

Please check off the appropriate symptoms

- Skin: "hives" (red blotches or welts which itch): severe swelling
- Eyes: tearing, redness, itching
- Lungs: shortness of breath, rapid breathing, cough, wheeze
- Gut: repeated vomiting, nausea, abdominal pain (diarrhea later)
- Brain: anxiety, agitation, or loss of consciousness
- Throat: tightness, trouble speaking, and trouble breathing
- Nose: running, itching, congested
- Mouth: itching, swelling of lips, tongue or mouth
- Heart/Circulation: weak pulse, loss of consciousness

In the event of an allergic reaction, the school nurse should proceed as follows:

1. If the child develops only hives (only skin problems) give antihistamine.
 - a. Dose: Benadryl _____mg by mouth
Oral antihistamine must be given only by nurse or parent.
 - b. Observe closely for additional symptoms for the next six hours; notify parent/guardian

2. If the child develops any of signs of severe reactions of anaphylaxis, **immediately**
 - a. Inject Epinephrine IM: Dose __. 15mg __.30mg
 - b. This dose of IM Epinephrine may be repeated in 15 minutes if symptoms reoccur.
 - c. Give the above dose of Benadryl by mouth
 - d. Notify parent/guardian, and call 911

3. If wheezing occurs, treat with: _____

**In the event of an allergic reaction when the school nurse is unavailable (field trip, after school activity, or athletics):
This order is in effect for the current school year only!**

_____ **Able to self medicate**

I give my permission for this child to self medicate when the school nurse is not available. This student is allowed to administer a pre-measured dose of an antihistamine simultaneously with the Epi-pen only for anaphylaxis. The child has been educated on symptoms of anaphylaxis and instructed in the proper method of self-administration of epinephrine.

_____ **Unable to self medicate**

This child is not able to self medicate at this time. In the event of an anaphylactic reaction when the nurse is not available, I give my permission for a **trained delegate** to administer a single dose of an Epi-pen, and call 911.

I understand that the delegate is not permitted by NJ State law to give benadryl.

Physician's Signature

Date

Parent Signature

Date

Physician's Stamp here

School Nurse Signature

Date