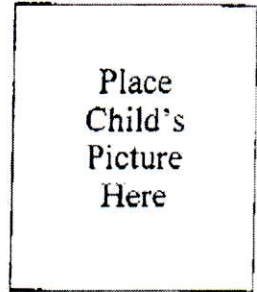


**Bee Sting Allergy Action Plan
Collingdale Nazarene Christian School (CNCS)**

Student's Name: _____ D.O.B: _____ Grade/Class _____



ALLERGY TO: _____

Asthmatic Yes* No *Higher risk for severe reaction

◆ **STEP 1: TREATMENT** ◆

Symptoms:

- If child has been stung, but *no symptoms*:
- Mouth Itching, tingling, or swelling of lips, tongue, mouth
- Skin Hives, itchy rash, swelling of the face or extremities
- Gut Nausea, abdominal cramps, vomiting, diarrhea
- Throat† Tightening of throat, hoarseness, hacking cough
- Lung† Shortness of breath, repetitive coughing, wheezing
- Heart† Thready pulse, low blood pressure, fainting, pale, blueness
- Other† _____
- If reaction is progressing (several of the above areas affected), give

Give Checked Medication**:

** (To be determined by physician authorizing treatment)

- Epinephrine Antihistamine
- Epinephrine Antihistamine
- Epinephrine Antihistamine
- Epinephrine Antihistamine
- Epinephrine Antihistamine
- Epinephrine Antihistamine
- Epinephrine Antihistamine
- Epinephrine Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ **STEP 2: EMERGENCY CALLS** ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

| Name/Relationship | Phone Number(s) | |
|-------------------|-----------------|-----------|
| a. _____ | 1.) _____ | 2.) _____ |
| b. _____ | 1.) _____ | 2.) _____ |
| c. _____ | 1.) _____ | 2.) _____ |

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

Parent/Guardian Signature _____ Date _____

Doctor Signature _____ Date _____