



# Emergency Care Plan



## BEE STING ALLERGY

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_

Asthmatic:  Yes  No (increased risk for severe reaction) Severity of reaction(s): \_\_\_\_\_

Mother: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

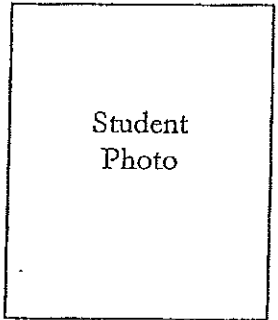
Father: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

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 give immediately.



STAFF MEMBERS INSTRUCTED:  Administration  Classroom Teacher(s)  Support Staff  Special Area Teacher(s)  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

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: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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