



Emergency Care Plan



BEE STING ALLERGY

Student: _____ Grade: _____ DOB: _____

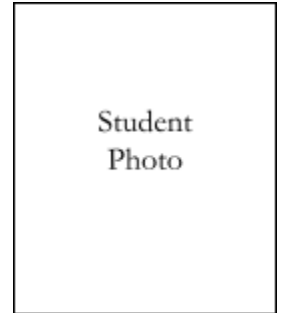
Asthmatic: Yes No (increased risk for severe reaction) Severity of reaction(s): _____

Parent/Guardian: _____ Cell #: _____ Work #: _____

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.

STAFF MEMBERS INSTRUCTED:

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

TREATMENT: Remove stinger if visible, apply ice to area. Rinsing 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.

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.

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: _____