



Emergency Care Plan



BEE STING ALLERGY

Student: _____ Grade: _____ School Contact: _____ DOB: _____

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

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

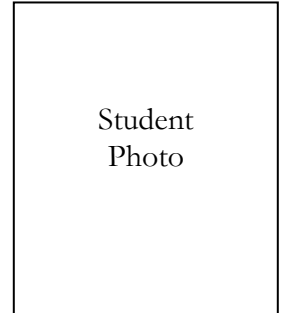
Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

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, using card to scrape (do not try to pull on stinger). Apply ice to area. Rinse 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 at _____ 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: _____