Sunman Dearborn Community Schools

Place Child's Picture Here

Anaphylactic Bee Sting Allergy Action Plan

Student's Name:_____ D.O.B:_____ Teacher:_____
ALLERGY TO:_____

Asthmatic Yes* No *Higher risk for severe reaction
911 MUST BE CALLED IF THE EPI PEN IS ADMINISTERED.

STEP 1: TREATMENT

Symptoms:	Give Checked Medication ** :
▪ If stung by bee, and no symptoms:	☐ EpiPen ☐ Antihistamine
▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ EpiPen ☐ Antihistamine
▪ Skin Hives, itchy rash, swelling of the face or extremities	☐ EpiPen ☐ Antihistamine
▪ Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ EpiPen ☐ Antihistamine
▪ Throat = Tightening of throat, hoarseness, hacking cough	☐ EpiPen ☐ Antihistamine
▪ Lung = Shortness of breath, repetitive coughing, wheezing	☐ EpiPen ☐ Antihistamine
▪ Heart = Thready pulse, low blood pressure, fainting, pale, blueness	☐ EpiPen ☐ Antihistamine
▪ Other = _____	☐ EpiPen ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give	☐ EpiPen ☐ Antihistamine

To be determined by physician authorizing treatment

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

May administer second dose of twinject after _____ mins. if symptoms return. YES NO (circle one)

DOSAGE: Kept in nurse's office: Yes___ No___ Kept in Backpack: Yes___ No___
Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 Twinject 0.15
(see reverse side for instructions)

Antihistamine: give _____ Exp. Date_____
medication/dose/route

Other: give_____ Exp. Date_____
medication/dose/route

STUDENT HAS BEEN INSTRUCTED TO SELF-INJECT Yes____ No____
Who instructed_____ Date_____

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/Relationships	Phone Number(s)
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____
c. _____	1.)_____	2.) _____

Parent Requests_____

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

Doctor's Signature_____ Date_____
(Required)

I give permission to school personnel to administer the above medication as instructed and agree to deliver the medication to the school in the original container with the label intact. I understand that it is the student's responsibility to report on time for this medication.

I will notify the school immediately of any changes in medication, dose, scheduled time, discontinuation of the above medication, or physician.

I give permission to school personnel to speak to the prescribing physician/healthcare provider if the dose exceeds the standard according to the Physicians Desk Reference (PDR) if needed. The call is to verify what is written for the protection of your child. I agree to absolve Sunman Dearborn School Corporation and employees from any events arising from the administration of this medication.

I agree that this plan may be shared with the appropriate staff members working with the students and bus drivers, on a need to know basis.

I will notify the school immediately of any changes in dose, time, physician, or discontinuation of the above medication.

BUS DRIVER: Bus#_____ Bus#_____ Bus#_____ Bus#_____

School policy states that students are NOT allowed to eat on the bus. Bus drivers please follow this policy.

Diabetic Students are the only exception to eat on the bus if they feel their blood sugar is low. Please do not allow them to carry nut products.

This student carries an epi-pen in their backpack? ____Yes____ No

If a child carries an epi-pen on the bus the bus driver is required to have yearly epi-pen training. Please contact the school nurse at:

_____

The bus driver can assist the child in administering the epi-pen if the driver has been trained by a nurse, or any school nurse. The life squad can administer the epi-pen.

PARENT Signature: _____ DATE _____

NOTES: