

# 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 #: \_\_\_\_\_

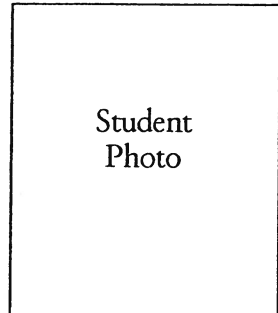
Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_

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 give immediately.**



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

Benadryl ordered:       Yes  No      Give \_\_\_\_\_ Benadryl per provider's orders

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: \_\_\_\_\_

Copy provided to Parent       Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_

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

Revised 1/08

**HEALTH HISTORY**  
**Caring for students with allergies**

**Student Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Does your child have asthma?** \_\_\_ yes \_\_\_ no ( asthma can increase the severity of the reaction)

**Other health concerns/medical problems?** \_\_\_\_\_  
\_\_\_\_\_

**Type of allergy and reaction** \_\_\_\_\_

**SAMPLES:** \_\_\_\_\_  
(Eggs-facial rash) \_\_\_\_\_  
(seafood-difficult breathing) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**At what age was the student diagnosed with the allergy?** \_\_\_\_\_  
**What symptoms led to the diagnosis?** \_\_\_\_\_

**Approximately how many allergic reactions has the student experienced?** \_\_\_\_\_  
**When was his/her last allergic reaction?** \_\_\_\_\_

**Does the child have an early awareness of an onset of an allergic reaction?** \_\_\_\_\_

**What treatment does the child usually require for an allergic reaction?** \_\_\_\_\_  
\_\_\_\_\_

**Has the child been hospitalized as a result of an allergic reaction?** \_\_Y\_\_N  
**How many times?** \_\_\_\_\_  
\_\_\_\_\_

**Has the student experienced an allergic reaction at school before?** \_\_\_\_\_  
**If so, please describe incident:** \_\_\_\_\_

**Is there anything else that the school should know to take the best care we can of your student?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

**Health care provider name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**All school health information is handled in a respectful and confidential manner. May the school health office staff share this information with school staff on a "need to know" basis?**  
**Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

---