Tunkhannock Area School District

Lynn McAndrew, RN

Allergy Action Plan (Bee Sting)

Name___________________________ School Year 20___ to 20___

Asthmatic Yes*☐ No☐ *Higher risk for severe reaction DOB____ /____ /____

Emergency Plan (to be completed by physician)

Treatment

Symptoms	Give Checked Medication	
✓ If a bee sting has occurred, but *no symptoms:*	☐EpiPen	☐Antihistamine
✓ Site of Sting- Swelling, redness, itching	☐EpiPen	☐Antihistamine
✓ Skin - Itching, tingling, or swelling of lips, tongue, mouth	☐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 BP, fainting, pale, blueness	☐Epipen	☐Antihistamine
✓ Other***** - ____	☐Epipen	☐Antihistamine
✓ If reaction is progressing (several of the areas affected), give	☐EpiPen	☐Antihistamine

The severity of symptoms can quickly change. ****Potentially life threatening***

Dosage

Epinephrine: Inject intramuscularly (circle one) EpiPen EpiPen Jr (see reverse side for instructions)
Does: ________________mg

Antihistamine: Give____
Medication/dose/route

Other: Give____
Medication/dose/route

Emergency Calls

1. ***Call 911***. State that an allergic reaction has been treated and additional epinephrine may be needed.
2. Parent/Guardian____ Home Phone ________________
   Work Phone ________________
   Cell phone ________________
3. Dr.____ at ________________
4. Emergency Contact (if parent cannot be reached)______________________________Phone______________

Parent/Guardian Signature ____

Physician Signature ____

Physician Printed Name ____**Address**________________________

Health Office Phone- 570.836.8267 TAHS Fax – 570.836.8251