# Insect Sting Allergy Action Plan

**Student's Name:** _____ **DOB:** _____ **Grade:** _____

**Parent/Guardian Name:** _____ **Phone Number:** _____

**Emergency Contact:** _____ **Phone Number:** _____

**Primary Physician:** _____ **Phone Number:** _____

**Symptoms of an Allergic Reaction May Include Any/All of:**

- **Mouth**: Itching & swelling of lips, tongue, or mouth
- **Throat:** Itching, tightness in throat, hoarseness or cough
- **Skin:** Hives, itchy rash, swelling of face and/or extremities
- **Stomach:** Nausea, abdominal cramps, vomiting, or 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!**

**TREATMENT: Remove stinger if visible, apply ice to area. Rinse contact area with water.**

Treatment should be initiated: ___ with symptoms ____ without symptoms

Benadryl ordered: YES or NO Give _____ Benadryl per provider's orders

Epinephrine ordered: YES or NO Special Instructions: _____

**IF ANY SYMPTOMS, BEYOND REDNESS OR SWELLING AT THE SITE OF THE STING, ARE PRESENT AND EPINIEPHRINE IS ORDERED, GIVE EPINIEPHRINE AND CALL 911**

Preferred Hospital (if transported): _____

Epinephrine provides a 20 minute response window. After epinephrine, a student may feel dizzy or experience an increase heart rate. This is a normal response. Student receiving epinephrine, should be transported to the hospital by ambulance. A staff member must accompany the student to the emergency room, if the parent/guardian or emergency contact, is not present.

**Parental Permission:**

I hereby request the school personnel, or its agents, to assist in the insect sting allergy management procedure for my child as prescribed by the doctor. I understand that there is no liability on the part of the school district, its agents or its personnel for civil damages as a result of assisting with this procedure, when the person acts as an ordinarily reasonable and prudent person would have acted under the same or similar circumstances. I want this plan implemented for my child while at school. I give my permission for exchange of confidential information, contained in the record of my child, between the nurse and physician. My signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the nurse.

Parent/Guardian Printed Name: _____ Date: _____

Parent/Guardian Signature: _____

Physician Signature: _____ Date: _____