Student Photo ID

Insect Allergy: Emergency Action Plan

Student's Name:	**School/Grade:**
Date of Birth:	**Contact Teacher:**
Parent/Guardian Name:	**Phone (Family):**
Address:	
Physician:	**RN:**
Emergency Number:	
Emergency Number:	
Emergency Number:	

Allergy to: _____

Weight: _____ lbs. **Asthma: _____ Yes (higher risk for a severe reaction)** **_____ No**

1. Any SEVERE SYMPTOMS after suspected sting:

One or more of the following:
LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue and/or lips)
SKIN: Many hives over body
Or **combination** of symptoms from different body areas:
SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT: Vomiting, diarrhea, crampy pain

Treatment:
1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin Monitoring
4. Give additional medications (if ordered)
   a. Antihistamine
   b. Inhaler (bronchodilator) if asthma

2. MILD SYMPTOMS ONLY:
MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Mild nausea/discomfort

Treatment:
1. GIVE ANTIHISTAMINE
2.. If symptoms progress (see above), USE EPINEPHRINE
3. Begin monitoring

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

This plan is subject to change but only with documentation from physician along with meeting with parents and staff. This plan will be shared with all teachers, support staff, and transportation personnel who are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if the health status of the student listed above changes, we change physicians, or there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian _____ Date _____

Registered Nurse _____ Date _____

MEDICAL REVIEW

I have reviewed the Individual Health Care Plan (IHP) for _____, and:

_____ I approve the IHP as written.

_____ I approve the IHP with the attached amendments.

_____ I do not approve of the IHP as written, and substitute orders are attached.

Physician_____ Date _____

Other Recommendations: _____

_____

_____

_____

_____