

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): _____

