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Insect Allergy: Emergency Action Plan

| Student's Name: | School/Grade: |
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| Date of Birth: | Contact Teacher: |
| Parent/Guardian Name: | Phone (Family): |
| Address: | |
| Physician: | RN: |
| Emergency Number: | |
| Emergency Number: | 0.0000 |
| 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 that 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 | |
| RN | Date | · · · · · · · · · · · · · · · · · · · |
| MEDICAL REVIEW | | |
| I have reviewed the attached Emergency Action Plan (EAP) for | | , AND: |
| I approve the EAP as written. | | |
| I approve the EAP with the attached amendments | • | |
| I do not approve of the EAP as written, and subst | itute orders are attached. | |
| Physician | Date | |
| OTHER RECOMMENDATIONS | | |
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