Insect Sting Allergy Action Plan

Student Name _____ Date of Birth _____ Grade ___ School Year _____

Allergy To:

_____

_____

Asthmatic: __ Yes __No

TREATMENT (To be completed by physician) A medication form must be filled out for each medication		
SYMPTOMS:	**GIVE CIRCLED MEDICATION (TO BE COMPLETED BY A PHYSICIAN)**	
If a sting has occurred, but NO SYMPTOMS	EpiPen	Antihistamine
MOUTH: Itching, tingling, or swelling of lips, tongue	EpiPen	Antihistamine
SKIN: Hives, rash, swelling of face or extremities	EpiPen	Antihistamine
GUT: Nausea, cramping, vomiting, diarrhea	EpiPen	Antihistamine
THROAT* : Tightening of throat, hoarseness, cough	EpiPen	Antihistamine
LUNG* : Shortness of breath, coughing, wheezing	EpiPen	Antihistamine
HEART* : Thready pulse, low blood pressure, fainting	EpiPen	Antihistamine
OTHER:	EpiPen	Antihistamine
If reaction is progressing or several of the above areas are affected	EpiPen	Antihistamine
Potentially life-threatening. 9-1-1 WILL BE CALLED IF EPIPEN IS ADMINISTERED		
Epinephrine (circle): EpiPen EpiPen Jr. Twinject 0.3mg Twinject 0.15mg Auvi-Q 0.15 mg Auvi-Q 0.3 mg		
Antihistamine (Name/Dose/Route):		

EMERGENCY CONTACTS

Name/Relationship to Student	**Phone number(s)**
1	1. 2.
2	1. 2.
3	1. 2.
Physician	

I give permission for school personned to follow this plan and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and corresponding forms. I also consent to the release of the information contained in this plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature	Date
Physician's Signature	Date
Nurse's Signature	Date