BEE STING ALLERGY TREATMENT PLAN

STUDENT'S NAME _____ **D.O.B.**_____

ASTHMATIC YES*____ NO____ *High risk for severe reaction

SIGNS OF ALLERGIC REACTION

Systems:	Symptoms:
Mouth	itching & swelling of the lips, tongue or mouth
Throat*	itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
Skin	hives, itchy rash and/or swelling about the face or extremities
Lung*	shortness of breath, repetitive coughing and/or wheezing
Heart*	"thready" pulse, "passing out"

The severity of symptoms can quickly change. *All above symptoms can potentially progree to a life-threatening situation.

ACTION FOR MINOR REACTION

1. **If only symptom(s) are:**_____
   give _____

Then call:

2. **Mother** _____, **Father** _____, **or emergency contact.**

3. **Doctor** _____ **at** _____

If condition does not improve within 10 minutes, follow steps for Major Reaction below.

ACTION FOR MAJOR REACTION

1. **If stung and/or symptom(s) are:** _____,

   Give _____**IMMEDIATELY!**
   MEDICATION/DOSE/ROUTE

THEN CALL:

2. **Rescue Squad (ask for advanced life support)**
3. **Parents**
4. **Doctor**

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent's Signature_____**Date**_____

Doctor's Signature_____**Date**_____
Doctor's Stamp

PEMBERTON TOWNSHIP PUBLIC SCHOOLS
Department of Pupil Personnel Services

ANAPHYLAXIS INDIVIDUAL EMERGENCY CARE PLAN

Student's Name _____ DOB: _____ Teacher: _____

ALLERGY TO: _____ Asthmatic: Yes___ No___

Parent/Guardian Telephone Numbers:

Name/Relationship	Home Phone	Work Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

This reaction **could** __ **could not**__ be described as anaphylactic. Presenting symptoms include:

Please check off the appropriate symptoms

- ❒ Skin: "hives" (red blotches or welts which itch): severe swelling
- ❒ Eyes: tearing, redness, itching
- ❒ Lungs: shortness of breath, rapid breathing, cough, wheeze
- ❒ Gut: repeated vomiting, nausea, abdominal pain (diarrhea later)
- ❒ Brain: anxiety, agitation, or loss of consciousness
- ❒ Throat: tightness, trouble speaking, and trouble breathing
- ❒ Nose: running, itching, congested
- ❒ Mouth: itching, swelling of lips, tongue or mouth
- ❒ Heart/Circulation: weak pulse, loss of consciousness

In the event of an allergic reaction, the school nurse should proceed as follows:

1. If the child develops only hives (only skin problems) give antihistamine.
   a. Dose: Benadryl ____mg by mouth
      Oral antihistamine must be given only by nurse or parent.
   b. Observe closely for additional symptoms for the next six hours; notify parent/guardian

2. If the child develops any of signs of sever reactions of anaphylaxis, **immediately**
   a. Inject Epinephrine IM: Dose__ .15mg __ .30mg
   b. This dose of IM Epinephrine may be repeated in 15 minutes if symptoms reoccur.
   c. Give the above dose of Benadryl by mouth
   d. Notify parent/guardian, and call 911

3. If wheezing occurs, treat with: _____

In the event of an allergic reaction when the school nurse is unavailable (field trip, after school activity, or athletics): This order is in effect for the current school year only!

_____ **Able to self medicate**

I give my permission for this child to self medicate when the school nurse is not available. This student is allowed to administer a pre-measured dose of an antihistamine simultaneously with the Epi-pen only for anaphylaxis. The child has been educated on symptoms of anaphylaxis and instructed in the proper method of self-administration of epinephrine.

_____ **Unable to self medicate**

This child is not able to self medicate at this time. In the event of an anaphylactic reaction when the nurse is not available, I give my permission for a trained delegate to administer a single dose of an Epi-pen, and call 911.
I understand that the delegate is not permitted by NJ State law to give benadryl.

_____ _____ _____ _____

Physician's Signature **Date** **Parent Signature** **Date**

Physican's Stamp here

_____ _____

School Nurse Signature **Date**