School District of Washington

Bee Sting Action Plan

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____ **Grade/Teacher:** _____

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

Place Student's Picture Here

Extremely reactive to the following stings _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the *student was stung*.

☐ If checked, give epinephrine immediately if the *student was stung*, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known 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, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

If Benadryl is administered per action plan, parents will be notified to pickup the student for closer monitoring.

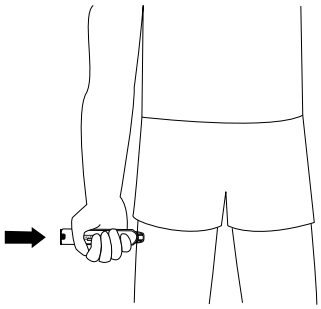
TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

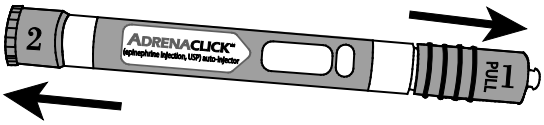
<u>SECOND DOSE ADMINISTRATION</u>: If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_____) Doctor:_____ Phone: (___)_____-_____

Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts

Name/Relationship: _____ Phone: (___)_____-_____

Name/Relationship: _____ Phone: (___)_____-_____

Self-Carry and Self Administration of Medication
This student will be allowed to carry the medications and supplies listed on this care plan on his/her person or to keep these medications and supplies in his/her locker or P.E. locker, as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of the use of these medications and supplies. If he/she feels the need to use the medications or supplies, he/she may use them and then report to the school nurse or office so that the use of these medications and supplies may be recorded and monitored. He/she will be required to demonstrate proper self-administration technique to the school nurse at the beginning of the year and as she deems necessary.

This Medical Management Plan has been approved by:

_____ _____
Physician/Health Care Provider Signature Date

The Washington School District shall incur no liability as a result of any injury arising from the student's self-management and administration of the medications and procedures listed in this care plan, and the parents/guardians shall indemnify and hold harmless the district and it's employees or agents against any claims arising out of the student's self-management and administration of medications and procedures. We, the undersigned, absolve the Washington School District of any responsibility in safeguarding our child's medication.
Parent Agreement? ☐ Yes ☐ No

Exchange of Information
I give permission for qualified school staff to contact the physician(s) listed on this care plan and discuss my child's medical conditions and treatment as needed.
Parent Agreement? ☐ Yes ☐ No

I give permission to the school nurse, trained personnel, and other designated staff members of **SCHOOL DISTRICT OF WASHINGTON** to perform and carry out the care tasks as outlined by _____'s Medical Management Plan. I also consent to the release of the information contained in this Medical Management Plan to all staff members, First Student Transportation Company, 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.
Acknowledged and received by:

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Received in Nurses Office on:_____