

Insect Allergy Action Plan

Student's

Name: _____ D.O.B: _____ Teacher: _____

ALLERGY TO: _____

Asthmatic Yes * No *Higher risk for severe reaction

STEP 1: TREATMENT

Symptoms:

Give Checked Medication**:

** (To be determined by physician authorizing treatment)

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> If an insect sting/bite has occurred, but no symptoms: | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Mouth Itching, tingling, or swelling of lips, tongue, mouth | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Skin Hives, itchy rash, swelling of the face or extremities | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Gut Nausea, abdominal cramps, vomiting, diarrhea | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Throat† Tightening of throat, hoarseness, hacking cough | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Lung† Shortness of breath, repetitive coughing, wheezing | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Heart† Thready pulse, low blood pressure, fainting, pale, blueness | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Other† _____ | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> If reaction is progressing (several of the above areas affected) | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |

The severity of symptoms can quickly change. †Potentially life-threatening.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give _____
medication/dose/route

Other: give _____
medication/dose/route

STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____ at _____

3. Parents _____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship Phone Number(s)

a. _____ 1.) _____ 2.) _____

b. _____ 1.) _____ 2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____

(Required)