# Insect Allergy: Emergency Action Plan

<table>
<thead>
<tr>
<th>Student’s Name:</th>
<th>School/Grade:</th>
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<tbody>
<tr>
<td>Date of Birth:</td>
<td>Contact Teacher:</td>
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<tr>
<td>Parent/Guardian Name:</td>
<td>Phone (Family):</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Physician:</td>
<td>RN:</td>
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<tr>
<td>Emergency Number:</td>
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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): ________________________________

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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 personnel who 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 __________________________

Registered Nurse ___________________________ Date __________________________

MEDICAL REVIEW

I have reviewed the Individual Health Care Plan (IHP) for ___________________________, and:

_____ I approve the IHP as written.

_____ I approve the IHP with the attached amendments.

_____ I do not approve of the IHP as written, and substitute orders are attached.

Physician ___________________________ Date __________________________

Other Recommendations: ____________________________________________

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