LITTLE CYPRESS-MAURICEVILLE CISD
INSECT STING ALLERGY ACTION PLAN

SCHOOL YEAR: _____
Adopted from: www.dadehealth.org

Student: _____ Grade: ____ DOB: _____
Teacher: _____ Classroom: _____

SEVERE ALLERGY TO: _____

Asthmatic: YES ☐* NO☐ * Higher risk for severe reaction

STEP 1: RECOGNIZE THE SYMPTOMS

If _____ is stung or is believed to be stung by a bee/wasp/insect and **shows the following symptoms, as ☑ by doctor:**

Symptoms: (Doctor, please ☑ all symptoms that require EpiPen administration)

- ☐ **Mouth** itching, tingling or swelling of the lips, tongue, mouth
- ☐ **Throat** tightening of throat, hoarseness, hacking cough
- ☐ **Skin** hives, itchy rash, swelling of the face or extremities
- ☐ **Gut** nausea, abdominal cramps, vomiting, diarrhea
- ☐ **Lung** shortness of breath, repetitive coughing, wheezing
- ☐ **Heart** weak or thready pulse, low blood pressure, fainting, pale, blueness
- ☐ **Other** _____

STEP 2: RESPOND

May administer benedryl _____mg when sting occurs.

Give EpiPen as directed per Authorization for Medication Form
(Doctor, please ☑ dosage to be administered)

☐ EpiPen JR. (0.15mg epinephrine)
OR
☐ EpiPen (0.3mg epinephrine)

Administer rescue breathing or CPR, if necessary.

STEP 3: EMERGENCY CALLS

1. **Call 911**
2. **Call Emergency Contacts**:

Name/Relationship	Phone Number	Alternate Phone Number
1.	1.	1.
2.	2.	2.
3.	3.	3.

_____ _____
Doctor Signature **Date** **Parent/Guardian Signature** **Date**

_____
Doctor Phone