(6/2011)

BISHOP HEELAN CATHOLIC SCHOOLS

INSECT BITE/OTHER ALLERGY ACTION PLAN

Student's Name_____DOB:_____

Allergy To:_____

Weight:_____lbs. Asthmatic ☐ Yes (Higher risk for severe reaction ☐ No

STEP 1: TREATMENT

Symptoms: **Give Ccecked Medication**

- Mouth (Itching, tingling or swelling of lips, tongue, mouth) ☐ Epinephrine ☐ Antihistamine
- Skin (Hives, itchy rash, swelling of the face or extremities) ☐ Epinephrine ☐ Antihistamine
- Gut (Nausea, abdominal cramps, vomiting, diarrhea) ☐ Epinephrine ☐ Antihistamine
- Throat (Tightening of throat, hoarseness, hacking cough) ☐ Epinephrine ☐ Antihistamine
- Lung (Shortness of breath, repetitive coughing, wheezing) ☐ Epinephrine ☐ Antihistamine
- Heart (Thready pulse, low blood pressure, fainting, pale, blueness) ☐ Epinephrine ☐ Antihistamine
- Other :_____ ☐ Epinephrine ☐ Antihistamine
- If reaction is progressing (several of the above areas affected), give: ☐ Epinephrine ☐ Antihistamine

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

Describe usual reaction(if known) and specific action to take:

MEDICATION (List medication, dose, route and time)

Antihistamine: _____

Other:_____

Epinephrine: inject intramuscularly (check one)

☐ EpiPen ☐ EpiPen Jr ☐ Twinject 0.3mg ☐ Twinject 0.15mg ☐ Adrenaclick 0.3mg ☐ Adrenaclick0.15mg

Document Medication and time given in Student's Medication Record.

STEP 2: EMERGENCY CALLS

1. Call 911. State that an allergic reaction has been treated , and additional epinephrine may be needed.
2. Dr. _____at(phone #)_____
3. Emergency Contact: Name/Relationship_____Phone_____
   2nd contact person_____ Phone_____

Parent/Guardian Signature_____Date_____

Doctor's Signature (Required)_____Date_____