# Waldorf High School of Massachusetts Bay
# Bee Sting Allergy Action Plan

## To be completed by a Licensed Prescriber

Examining Licensed Prescriber: Please complete and return to student

Name of Student: _____Date of Birth: _____

Parent Contact: _____

Home#: _____ Cell#: _____

Asthmatic: Yes ___ No ___ (increased risk for severe reaction) Severity of reaction(s): _____

**Symptoms of an allergic reaction may include any/all of these:**

- **Mouth** Itching and swelling of lips, tongue or mouth
- **Throat** Itching, tightness in throat, hoarseness, cough
- **Skin** Hives, itchy rash, swelling of face and extremities
- **Stomach** Nausea, abdominal cramps, vomiting, diarrhea
- **Lung** Shortness of breath, repetitive cough, wheezing
- **Heart** "Thready pulse", "passing out", faint, pale, dizzy

**The severity of symptoms can change quickly –**
**It is important that treatment is given immediately.**

***If any symptoms beyond redness or swelling at the site of the sting are present and Epinephrine is ordered, give Epinephrine immediately and call 911.**

**Treatment:**

Treatment should be initiated: ____ with symptoms ____ without waiting for symptoms

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

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

Stay with student: alert healthcare professionals and parent.

Physician/Healthcare Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____