EMERGENCY ACTION PLAN – BEE STINGS

Students Name:____Birthdate:__________________________

Parents Name:____Phone Number:______________________

My child has a history of severe reaction to bee stings. In the event my child should be stung by a bee, I hereby request and authorize school personnel to administer his/her medication as directed.

Special Instructions: (Please be very specific)

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If Epinephrine (EpiPen) is given, medical treatment will be sought within 20 minutes. If the school is unable to reach the parent/guardian or other authorized family member, 911 will be called and child will be transported to the nearest hospital for emergency medical treatment.

Please indicate below how you would like us to proceed in seeking medical treatment if Epinephrine is given. (number each in desired order of action)

( ) Call Father ______________________________________Phone Number:__________________________

( ) Call Mother ______________________________________Phone Number:__________________________

( ) Contact ____Phone Number:__________________________

( ) Contact ____Phone Number:__________________________

( ) Call Rescue Unit (911)

*Parents, please note that you must contact the bus garage to arrange for these medications to be made available to the bus driver for use in an emergency as directed above.

Parents Signature: ____Date: __________________________

Nurse's Signature: ____Date: __________________________