MINERSVILLE AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

BEE STING ALLERGY ACTION PLAN

NAME: _____ GRADE/SECTION: _____DOB: _____

NAME OF DR. DIAGNOSING THE ALLERGY: _____

Symptoms of the child's reaction (Please be specific, ex. Swelling at the site of the sting, full body rash, difficulty breathing, etc.) _____

_____

_____

_____

Doctor's Orders:

School Year: _____

_____Benadryl Dosage: _____

_____EpiPen Dosage: _____

_____Other _____ Dosage: _____

Doctor's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Contacts: In the event of a bee sting, the following contacts will be notified:

1. _____ _____ _____
   Name Relationship to Student Phone Number
2. _____ _____ _____
   Name Relationship to Student Phone Number
3. _____ _____ _____
   Name Relationship to Student Phone Number
4. _____ _____ _____
   Name Relationship to Student Phone Number
5. _____ _____ _____
   Name Relationship to Student Phone Number

Hospital Preference: _____