Rescue Union School District
Bee Sting Allergy Health Plan
School Year: _____

Student Name_____Teacher_____Grade_____
Home Phone #_____
Mother's Name_____Work #____ _____Cell# _____
Father's Name_____Work #_____Cell#_____
Emergency Contacts:
(1)_____
(2)_____
Mode of Transportation to School:_____

☐Yes ☐No Student wears a medical alert I.D. bracelet/necklace.

Date of last reaction: _____

Description of last reaction: _____

_____

_____

Action to be taken at school for allergic reaction:

- ☐Yes ☐No Medications at school. (Note: If medications are prescribed, school staff will follow the healthcare provider's instructions on the medication form.)

Other: _____

_____

_____

Parent/Guardian Signature: _____Date:_____
School Nurse Signature: _____Date:_____
Copy of Care Plan Given to Teacher/Others (list others): Date: _____

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