BEE/WASP/SEVERE ALLERGY ACTION PLAN

Student Name/Grade ____

My child is allergic to: ____

Describe the reaction your child has:

__ Localized swelling and/or redness

__ Breathing difficulties

__ Rash

__ Other—please list

____

Medication required:

Benadryl __ Yes __ No

Epi-Pen __ Yes __ No

**If your child needs to keep medicine at school, please have your physician complete the enclosed form. It must be signed by you and your physician.

____

______________________________________ ________________________

Parent Signature Date