ישיבת עקיבא
FARBER
HEBREW DAY SCHOOL

Effective Date: _____

Place Child's Picture Here

ALLERGY/BEE STING ACTION PLAN

Student's Name: _____ Date of Birth: _____ Grade: _____

ALLERGY TO: _____

Please check if asthmatic: _____ High risk for severe reaction _____ Yes _____No

ACTION FOR MINOR REACTION

If symptom(s)are: _____

administer: _____
(medication and dose)

ACTION FOR MAJOR REACTION

If symptom(s)are: _____

administer: _____
(medication and dose)

CALL 911 (ask for advanced life support) and for any reaction CALL:

_____ _____
Mother's name and phone number Father's name and phone number

DO NOT HESITATE TO CALL 911

I have instructed this student in the proper way to use the above emergency medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

_____Yes _____No

Physician's Signature: _____ Date: _____

I give my permission and authorization for this medication to be administered as prescribed above and for doing so, I hereby release from liability and agree to indemnify any personnel or volunteers of Farber Hebrew Day School for any action or inactions associated with the administration of medication to the above student.

Parent/Legal Guardian Signature: _____

Phone Number: _____ Home _____ Work _____ Cell

Other Phone Numbers: _____