

Bee or Insect Allergy Form

Student Name _____ Date of Birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating bee allergy: _____ Phone: _____

Do you think your student's bee allergy may be life-threatening? ____ No ____ Yes (If YES, please see the school nurse as soon as possible).

Did your student's health care provider tell you the bee allergy may be life-threatening?

____ No ____ Yes (If YES, please see the school nurse as soon as possible.)

History and Current Status What type of stinging bee or insect has your student reacted to?

How many times has your student had a reaction? ____ Never ____ Once ____ More than once, please describe: _____ When was the last reaction? _____

Are the reactions: ____ staying the same ____ getting worse ____ getting better

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

____ No ____ Yes, please describe: _____

Has your student ever received or used an EpiPen or other injection as treatment: ____ No ____ Yes, please describe: _____

Triggers and Symptoms What are the signs and symptoms of your student's allergic reaction? (Be specific, include things your child might say.)

How quickly do the signs and symptoms appear after the sting?

Treatment Does your student understand how to avoid getting a bee sting or insect bites? ____ Yes ____ No What do you do at home if there is a reaction to a bee sting or insect bite?

Does your student understand how to avoid foods that cause allergic reactions? ____ Yes ____ No What treatment or medication has your health care provider recommended for use in an allergic reaction?

_____ Have you used the treatment or medication? ____ No ____ Yes

Does your student know how to use the treatment? ____ No ____ Yes

Please describe any side effects or problems your child had in using the suggested

Treatment: _____

If medication is to be available at school, have you filled out a medication form for school?

____ Yes ____ No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

____ Yes ____ No, I need to get the medication/treatment and bring it to school.

Parent Signature: _____ Date: _____