Bee Sting Allergies & Allergic Reactions Form

Name of Student: _____ Grade: _____

_____ My student is allergic to bee stings
_____ My student is allergic to other: _____

My student has had these reactions: (Check all that apply)

_____ Swelling at the site
_____ Swelling spread beyond the area of the sting
_____ Hives or itching sensation
_____ Rash over entire body
_____ Difficulty breathing, coughing, wheezing or sneezing
_____ Difficulty swallowing, or a choking sensation
_____ Nausea
_____ Other_____

_____ My student's reaction **may be life threatening** and requires immediate medical attention. **Do not wait for symptoms to appear**.

1. Call 911
2. If an EpiPen is to be administered fill out the consent.
3. Transport to the following hospital:_____
4. Contact the following person:_____ #_____
5. My student's doctor is:_____ #_____

My student's reaction is **not** life threatening but the following will need to be done:

1. _____
2. _____
3. _____

I understand that the school will call 911 if any of the following signs or symptoms of a severe allergic reaction/anaphylactic shock should appear:

- Difficulty breathing, coughing, wheezing, sneezing
- Difficulty swallowing, choking sensation
- Nausea/Vomiting
- Feeling of severe anxiety
- Hives or itching sensation

I certify that the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my student's health status that are relevant to the information requested by this form.

Parent/Guardian Signature: _____
Printed Name: _____

Date:_____ Phone #_____