ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/ St. Mary's County Health Department

INSECT ALLERGY INFORMATION

Student's Name: _____ Date of Birth:

Allergic to: _____

Diagnosed by Doctor: ☐ Yes ☐ No Doctor's Name: _____

Date of Last Allergic Reaction:

Do you consider the insect allergy to be life threatening to your child? ☐ Yes ☐ No **If Yes, an Insect Allergy Emergency Action Plan may be needed at school.**

Please list the type of insect allergy:

Please list any medications your child takes:

Name of Medication	Dose	Frequency

If medication is needed at school, please have your doctor complete a Medication Authorization form.

Does your child have a prescribed EpiPen for emergency use? ☐ Yes ☐ No

Please check only those symptoms which you have observed when your child has had an allergic insect reaction:

- ☐ swelling about the face or extremities
- ☐ difficulty breathing, shortness of breath or wheezing
- ☐ difficulty swallowing or choking
- ☐ repetitive coughing dizziness or fainting
- ☐ shock (fall in blood pressure and increased thready pulse rate)
- ☐ unconsciousness
  itching or swelling of lips, tongue, or mouth
- ☐ nasal congestion
- ☐ runny nose, sneezing, or sniffling
- ☐ sore throat or throat clearing, "hacking"
- ☐ cough
- ☐ hoarseness
- ☐ nausea or vomiting abdominal cramps or diarrhea
- ☐ hives
- ☐ Other:

Progression of symptoms were: (Please check.)

- ☐ increasing and worsening rapidly
- ☐ early, mild symptoms with apparent resolution followed by rapid development of lung and/or heart symptoms
- ☐ other

How long after being exposed to the allergen did your child develop symptoms? (Please check.)

- ☐ immediately
- ☐ within 15 – 20 minutes
- ☐ within an hour
- ☐ longer than one hour (specify time) _____

Has your child ever been hospitalized (emergency room) for an allergic reaction? ☐ Yes ☐ No

Does your child know to avoid the allergen? ☐ Yes ☐ No

Parents'/Legal Guardians' Signature _____ Date _____