Our Mission
To achieve educational excellence and to inspire a life-long passion for learning.

ALEXANDRIA
Public Schools

Our Vision
To be an extraordinary school district that tailors learning for each child, by working together!

BEE OR INSECT ALLERGY HISTORY FORM

Student Name:		**Date of Birth:**
Parent/Guardian:	**Telephone #:**	**Cell/Work #:**
Health Care Provider's Name: (treating allergy)	**Clinic's name & phone #:**	

Do you think your student's bee/insect allergy may be life-threatening? ☐Yes ☐No

Does your student's health care provider think the bee allergy may be life-threatening? ☐Yes ☐No

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? ☐Yes ☐No

If YES, please describe: _____

Has your student ever received or used an EpiPen® or other injection as treatment? ☐Yes ☐No

If 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? _____seconds _____minutes

_____hours _____days

Treatment

Does your student understand how to avoid getting a bee sting or insect bite? ☐Yes ☐No

What do you do at home if there is a reaction to a bee sting or insect bite? _____

What treatment or medication has your health care provider recommended for an allergic reaction?

Please explain: _____ ☐None

Have you used the treatment or medication? ☐Yes ☐No

Does your student know how to use the treatment or medication? ☐Yes ☐No

Please describe any side effects or problems your student had in using the suggested treatment or medication. _____

_____

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 or treatment supplies to school?

☐Yes

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

What do you want the school to do in case of a bee sting or insect bite? _____

Parent/Guardian Signature:	Date:
Health Paraprofessional:	Date:
Registered Nurse:	Date: