Lake Stevens School District

G4: Allergy Screening Form (Non-Food Allergens)

Inspiring Excellence
LAKE STEVENS
School District

Student Name: _____ **Date of Birth:** _____

Parent/Guardian: _____ **Home Phone:** _____ **Cell:** _____

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

1. Allergy

Your student is allergic to: ☐ Bee ☐ Insect ☐ Animal ☐ Other; specify: _____

Do you think your student's allergy may be life-threatening?

☐ No ☐ Yes (If YES, please see the school nurse.)

Does your student's health care provider think the allergy may be life-threatening?

☐ No ☐ Yes (If YES, please see the school nurse.)

2. History & Current Status

What type of stinging bee, insect, or animal has your student reacted to? _____

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once

Please describe reaction: _____

When was the last reaction? _____

The reactions are: ☐ 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: _____

3. Triggers and Symptoms

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

_____

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

_____ seconds _____ minutes _____ hours _____ days

4. Treatment

Does your student understand how to avoid getting a bee sting/insect bite/animal?

☐ No ☐ Yes

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

_____

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

_____

Have you used the treatment or medication?

☐ No ☐ Yes

Does your student know how to use the treatment or medication?

☐ No ☐ Yes

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: _____

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