

WOODSTOCK ACADEMY

BEE STING/FOOD ALLERGY QUESTIONNAIRE

Dear Parent/Guardian:

Your child's health record indicates an allergy to bee/insect stings or to a food/substance. To update this record please complete this questionnaire as it applies to your child and return to the school nurse. Thank you for your cooperation.

If your child requires medication to control symptoms, please remember, no medication may be given, including over the counter medicines (Benadryl) without a parent/guardian's AND physician's written authorization.

Manifestation of the allergy: (Please check the symptoms your child develops).

_____ Swelling only at the site of the sting/bite

_____ Generalized swelling. What areas of the body are usually involved?

_____ lips, _____ tongue, _____ throat, other _____

_____ Itching mouth

_____ Hoarseness

_____ Tightness in the throat, difficulty swallowing

_____ Cough, chest tightness, difficulty breathing

_____ Stomach cramps, vomiting, or diarrhea

_____ Fainting, pallor, dizziness

Management of the allergy:

My child has a food/substance intolerance to _____.

He/she requires no medication or further treatment. Signature _____.

My child experiences a local (swelling/redness at the site) reaction to bee/insect stings, which requires no medication at school. Signature _____.

My child has a SEVERE FOOD ALLERGY to _____.

SEVERE BEE STING ALLERGY _____ which requires the medication _____ to be given at school. I will provide the medication and proper authorization.

Signature _____

Name of student: _____ Grade _____

Parent/Guardian's name (print or type) _____ Relationship _____

Signature _____ Date _____ Tel.(day) _____

Name & telephone number of person to contact in case of emergency:
