Bee Sting Allergy

Date:_____________

*Please fill out this form and turn it in to your student's secretary. A new form must be completed every school year!

Student Name:____ DOB:_____________________________

School:____ Teacher:__________________________

What type of insect sting is your student allergic to? (Please check all that apply.) Bee: ☐ Wasp: ☐ Hornet: ☐ Yellow Jacket: ☐ Other:_________________☐
What are your student's allergic reaction symptoms? (Please check all that apply.)
LUNGS: (Breathing Problems) Wheezing: ☐ Shortness of Breath: ☐ Coughing: ☐ Difficulty Speaking: ☐
THROAT: (Upper Airway Problems) Hoarseness: ☐ Swallowing Difficulty: ☐ Breathing Difficulty: ☐
HEART: (Circulation Problems) Blue lips: ☐ Faint: ☐ Dizziness: ☐
GUT: (Intestinal Reactions) Vomiting: ☐ Cramping: ☐ Diarrhea: ☐
SKIN: Hives: ☐ Redness: ☐ Swollen Face: ☐
MOUTH: Swelling of lips: ☐ Swelling of tongue: ☐ Metal Taste: ☐
BRAIN: (Mental Changes) Feeling of Impending Doom: ☐ Anxiety: ☐ Confusion: ☐
Other Symptoms: ____ ☐
Does your student have an Epipen for this allergy? Yes: ☐ No: ☐
If yes, what kind/brand of Epipen does your student have? ____
Where is the Epipen located? (Please check all that apply.) Office: ☐ Student Backpack: ☐ Student Locker: ☐
Does your student take Benadryl when having a reaction to this allergy? Yes: ☐ No: ☐
(Please explain/provide specific instructions.)
Does your student take any other medications when having a reaction to this allergy? Yes: ☐ No: ☐
(Please explain/provide specific instructions)
Have you filled out the form: __________________________ for your student for this school year and given a copy to the office? Yes: ☐ No: ☐
Do you have a Care Plan or Action Plan from your student's Doctor? (Please attach a copy if so!) Yes: ☐ No: ☐

Additional Comments: ____

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Date:__________

Parent/Guardian Name (printed): ____

Signature:____