SCHOOL HEALTH SERVICES

Student_____Grade/Teacher_____ Date_____

Dear Parent/Guardian:

You have indicated that your child has had an allergic reaction to bee stings, insect bites, or foods. In order to provide prompt care, comprehensive information is needed. Please complete the following questionnaire and return it to the Health Suite.

Date of last reaction: _____
Cause of reaction: ____Insect sting ____Bee sting ____Food
Known allergies:_____
Description of reaction – check applicable symptoms:
___ Itching of skin
___ Rash/Hives – Location_____
___ Swelling – Location_____
___ Nausea
___ Vomiting
___Abdominal cramps or Diarrhea
___ Light-headedness or Fainting
___ Drop in blood pressure
___ Difficulty breathing (Shortness of breath)
___ Violent sneezing, runny nose, or nasal obstruction
___ Wheezing
___ Hoarseness

Treatment required:_____

Medication ordered by physician:_____

If medication is needed for reactions, a physician's note describing treatment procedures/medications to be administered is required. A physician's medication certificate is on the back of this form for your convenience. For severe reactions, Epi-Pens are preferred over Anakits. All medication, prescription or over-the-counter, must be provided by the parent/guardian in original pharmacy containers.

Thank you,

School Nurse