

STUDENT SERVICES



OCEANSIDE UNIFIED SCHOOL DISTRICT
2080 Mission Avenue • Oceanside CA 92058 • (760) 966-7802

INSECT STING INFORMATION

Student _____ Date _____

School _____ Grade _____ Room _____

Dear Parent/Guardian:

You noted in the health history that your child has an allergy to bee/insect stings.

► If stung does this student have:

1.	Difficulty breathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Swelling of tongue or lips?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Rash or hives over entire body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	► How soon after sting? _____		
4.	Swelling and itching at site of sting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	► How soon after sting? _____		

Is medication to be dispensed at school ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____
Name of medication	_____	Dosage
<p>IF MEDICATION IS TO BE DISPENSED AT SCHOOL, YOU MUST SEND MEDICATION AND MEDICATION PERMISSION FORM TO THE SCHOOL HEALTH OFFICE</p>		

► Please return as soon as possible.

Sincerely,

School Nurse

Parent Signature

Date

Enclosed: INSECT STING ALLERGY ACTION PLAN
MEDICATION TAKEN BY STUDENT HS-22