Bee or Insect Allergy Information for School

Student Name: _____ Date of birth: _____ Date: _____

Parent/Guardian: _____ Cell: _____ Work: _____

Health Care Provider treating bee allergy: _____ Phone: _____

Do **you think** your student's bee allergy may be **life-threatening**? ❑ No ❑ Yes
(If YES, please see the school nurse as soon as possible)
Does your student's **health care provider think** the bee allergy may be **life-threatening**? ❑ No ❑ Yes
(If YES, please see the school nurse as soon as possible)

History and Current Status

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

How many times has your student had a reaction? ❑ Never ❑ Once ❑ More than once, explain:

_____

When was the last reaction? _____

Are the reactions: ❑ staying the same ❑ getting better ❑ getting worse

Triggers and Symptoms

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

_____

How quickly do the signs and symptoms appear after the sting?
_____ seconds _____ minutes _____ hours _____ days

Treatment

Has your student ever needed treatment at a clinic or hospital for an allergic reaction? ❑ No ❑ Yes

If YES, explain: _____

Has your student ever received or used an EpiPen or other injection as treatment? ❑ No ❑ Yes

If YES, explain: _____

Does your student understand how to avoid getting a bee sting or insect bite? ❑ Yes ❑ No

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

_____

What treatment or medication has your Health Care Provider recommended for use in 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 any: ___

_____

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/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 at school?

Parent/Guardian signature: _____ Date: _____

RN signature _____Date_____