

**Colville School District
School Bee or Insect Assessment Form**

Click or tap here to enter text.

Click or tap to enter a date.

Student Name

Date of Birth

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

Parent/Guardian

Phone/Cell

Work

Click or tap here to enter text.

Click or tap here to enter text.

Health Care Provider (Name) 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?

Click or tap here to enter text.

How many times has your student had a reaction? ☐ Never ☐ Once ☐ More than once, please describe: When was the last reaction?

Click or tap here to enter text.

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

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

☐ No ☐ Yes, please describe:

Has your student ever received or used an epinephrine auto injector as treatment? ☐ No ☐ Yes, please describe: Click or tap here to enter text.

Triggers and Symptoms

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

Click or tap here to enter text.

Treatment

Does your student understand how to avoid getting a bee sting or insect bite?

☐ No ☐ Yes

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

Click or tap here to enter text.

What treatment or medication has your health care provider recommended or prescribed for an allergic reaction?

Click or tap here to enter text.

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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 prescribed treatment or medication.

Click or tap here to enter text.

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 or treatment supplies to school?

☐ Yes

☐ No, I need to get the medication/treatment and bring it to school.

How can we help your student manage their allergy at school?

Click or tap here to enter text.

Other

Is your student involved in school sponsored after school activities/sports? ☐ No ☐ Yes

If yes, please list:

Is there anything else school staff should be aware of?

Click or tap here to enter text.

I give consent to share with the classroom that my child has a life-threatening insect or bee allergy.

☐ Yes

☐ No

Click or tap here to enter text.

Parent/Guardian Signature

Click or tap here to enter text.

Reviewed by RN

Adapted with permission from ESD 171 SNC Program

Click or tap to enter a date.

Date

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Date