

## Bee or Insect Allergy Form

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell/work: \_\_\_\_\_

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? \_\_\_\_\_

How many times has your student had a reaction?  Never  Once  More than once, please describe:  
\_\_\_\_\_

When was the last reaction? \_\_\_\_\_

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 Epi-pen® or other injection as treatment?  No  Yes, please describe:  
\_\_\_\_\_

### Triggers and Symptoms

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

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

### Treatment

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 an allergic reaction?  
\_\_\_\_\_  None

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 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.

What do you want the school to do in case of a bee sting or insect bite? \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_