



- Student Office File
- Student Medical File

Bee or Insect Allergy Form (2022-2023)

Page 1 of 2

Student Last Name, First Name _____

Birth Date _____

Grade _____

Yes No Do you think your student's bee or insect allergy may be life-threatening?
(If yes, please contact the main office as soon as possible).

Yes No Did your student's health care provider inform you the bee or insect allergy may be life-threatening?
(If yes, please contact the main office 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

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

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? _____

Yes No Have you used the treatment or medication?

Yes No Does your student know how to use the treatment or medication?

Please describe any side effects or problems your student had in using the suggested treatment or medication.



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Student Last Name, First Name

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If medication is to be available at school, have you submitted a **Permission for Prescription Medication** to school?

- Yes
- No, I need to acquire the form, have it completed by a licensed health professional and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies (in original packaging) to school?

- Yes
- No, I need to bring the medication/treatment to school and submit a **Permission for Prescription Medication** form to school.

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

I give consent to share, with the classroom, that my child has a bee sting or insect bite allergy.

- Yes
- No

Print Name of Licensed Health Professional (LHP) treating bee/insect allergy

Telephone Number

Signature of both Parents/Custodial Parent/Guardian

Date of Signature

Telephone Numbers: **HOME**

WORK

CELL

Mother/Guardian _____

Father _____
