

Bee Sting Allergy History

Student Name _____ Date of Birth _____
 ID# _____ Grade _____ School _____
 Parent/Guardian Name(s) _____
 Mother Telephone Home# _____ Work# _____ Cell# _____
 Father Telephone Home# _____ Work# _____ Cell# _____
 Emergency Contact _____ Relationship to Student _____
 Home Telephone# _____ Work or Cell # _____
 Health Care Provider _____ Telephone # _____

1. Is your child's allergy considered life threatening?
 No Yes If yes, by State Law, your child may not attend school until the health care provider orders for this condition have been provided. **Please contact the School Nurse.**
2. Does your child have asthma? No Yes
3. Does your child have any other health condition(s) or medication allergies we should be aware of?
 No Yes, explain _____
4. When was your child last stung? _____
5. Describe how your child reacts to a bee sting.
 Local swelling Hives Difficulty Breathing Other _____
6. Has your child received medical care because of a bee sting?
 No Yes Health Care Provider Name _____
 Approximate Date _____

7. **How do you want the school to treat a bee sting should one occur?**

8. Does your child require medication at school? No Yes, list medications below.

Medication Name	Amount	When to Use

9. This is our bee sting allergy emergency plan. If you want us to follow a different plan, please have your health care provider write specific orders.

Call 911 for help if:

- EpiPen is used
- Symptoms of allergic reaction develop
- Parent/student request
- Doctor's orders

 Signature of Parent/Guardian _____
 Date

