MONROE SCHOOL DISTRICT

Bee/Insect Allergy Form

Student Name: _____ Date of Birth:_____ Date: _____

Parent/Guardian: _____ Phone: _____Cell/Work:_____

Name of Health Care Provider treating bee/insect 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.)

History and Current Status

What type of stinging bee or insect has your child 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 EpiPen® or other injection as treatment? ☐ No ☐ Yes
please describe:_____

Has your student had allergy testing? ☐ 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? ☐ No ☐ Yes

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.
_____

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

- **If medication is needed at school,** please have your child's Health Care Provider complete the Authorization for Administration of Medication form. Bring the completed form and medication to school before your child begins attending.

This information may be used to create an individualized plan for your students care and will be shared with staff on a need to know basis.

Parent/Guardian Signature: _____ Date: _____