St. David Unified School District

Collaboration ❦ Positivity ❦ Preparedness

BEE OR INSECT ALLERGY ASSESSMENT FORM

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

Parent/Guardian:_____ Phone:_____ Cell/Work: _____

Health Care Provider (name) treating bee/insect allergy:_____ Phone: _____

Do **you think** your child's bee/insect 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/insect allergy may be **life-threatening**? ❑ No ❑ *Yes

If YES, please see the school nurse as soon as possible.

History and Current Status

What time 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

*If yes, please describe:_____

Has your student ever received or used an EpiPen® or other injection as treatment? ❑ No ❑ *Yes

*If 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 or insect bite? ❑ 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.

_____

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: _____