



BEE/WASP STING ALLERGY RECORD

To the parents/guardians of _____ Grade _____

According to our records you have informed the school that you child is allergic to bee or wasp stings. Please complete the information below. This will help school-staff know the type of reaction, which most closely describes the one your child has had in the past. Please return this form to the school nurse. This information will be shared with appropriate staff to protect the health and safety of your child.

My child’s reactions to bee/wasp stings can be best described as follows:

- YES NO A local reaction at the site of the sting with swelling and Redness around the area if the sting.
- YES NO A delayed reaction can occur from 2 hours to 3 weeks after the Sting. Symptoms include fever, rash, swelling, and joint pain.
- YES NO After the sting: the child immediately experiences itching, swelling Of different body parts, hives, shortness of breath, weakness, dizziness, or unconsciousness. This is a life threatening reaction

Does your child require medication at the time of the sting?

YES NO Name of medication: _____

If you plan to have medication available at school, medication forms must be completed and signed by you and your doctor. You may receive medication forms in the school clinic.

If a bee/wasp sting occurs in school, the student will be given basic first aid. If necessary, the student will be transported by rescue squad to the nearest hospital.

Please contact the school nurse if you have any questions.

x _____
Parent Signature

Date