Bee or Insect Allergy Assessment Form

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____Phone: _____Cell/work: _____

Health Care Provider (name) treating bee allergy: _____Phone_____

Do **you think** your child/student's bee 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 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/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 child/student ever needed treatment at a clinic or the hospital for an allergic reaction? ❑ No ❑ Yes
Please describe:_____

Has your child/student ever received or used an EpiPen® or other injection as treatment? ❑ No ❑ Yes
Please describe:_____

Triggers and Symptoms

What are the signs and symptoms of your child/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 child/student understand how to avoid getting a bee sting or insect bite? ❑ Yes ❑ No

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 child/student know how to use the treatment or medication? ❑No ❑ Yes

Please describe any side effects or problems your child/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: _____

From: *Guidelines for Care of Students with Anaphylaxis (March 2009) OSPI Publication 09-0009*