

Bee Sting Allergies & Allergic Reactions Form

Name of Student _____ Grade _____

_____ My child is allergic to Bee Stings

_____ My child is allergic to other: _____

My child has had these reactions: (Check all that apply)

- _____ Swelling at the site.
- _____ Swelling spread beyond the area of the sting.
- _____ Hives or itching sensation.
- _____ Rash over entire body.
- _____ Difficulty breathing, coughing, wheezing or sneezing.
- _____ Difficulty swallowing, or a choking sensation.
- _____ Nausea
- _____ Other _____

_____ My child's reaction **may be life threatening** and requires immediate medical attention. **Do not wait for symptoms to appear.**

1. Call 911
2. If an Epi-Pen is to be administered fill out the consent.
3. Transport to the following hospital: _____
4. Contact the following person: _____ # _____
5. My child's doctor is: _____ # _____

My child's reaction is **not** life threatening but the following will need to be done:

1. _____
2. _____
3. _____

I understand that the school will call 911 if any of the following signs or symptoms of a severe allergic reaction/anaphylactic shock should appear:

- Difficulty breathing, coughing, wheezing, sneezing.
- Difficulty swallowing, choking sensation.
- Nausea/Vomiting.
- Feeling of panic.
- Hives or itching sensation.

I certify that the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____ Phone # _____