

## BEE STING ALLERGY RECORD

Child's Name \_\_\_\_\_ Date \_\_\_\_\_  
Parent's Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
Physician Treating Child's Allergies \_\_\_\_\_

1. Briefly describe your child's symptoms when stung by a be:
2. Any Respiratory Problems?
3. Name the medications taken routinely, the dose, how often taken, when, and under what circumstances additional doses should be given.
4. Does your child need medication at school?
5. When was the last time your child was stung by a bee?
6. Has your child required a trip to the emergency room or doctor because of a bee sting?
7. How do you want the school to treat a bee sting if it should occur?
8. If the child does not respond to the treatment and we are unable to reach you, what action does the parent/guardian advise school personnel to take?

COMMENTS:

Signature of parent or guardian \_\_\_\_\_

To the parents of \_\_\_\_\_ Room \_\_\_\_\_

Dear Parent,

You have told us that your child is allergic to bee stings.

Please fill out the attached school allergy record and return it. I will share the information with the appropriate personal such as your child's classroom teacher(s), playground aids and physical education teacher.

To help your child, please let us know of changes in your child's allergy status or medication schedules. If your child is not allergic to bees, please let me know, so I can update my files.

Sincerely,

School Nurse