Greensburg Salem School District

# BEE STING ALLERGY

Dear Parent/Guardian: Name: _____

Your child's medical history indicates that he/she has a bee sting allergy. Because of the potential seriousness of this allergy we would like to know specifically how your child reacts to a bee sting. Please complete this form and return it promptly to the school nurse.

## PLEASE CHECK THE SYMPTOM(S) THAT YOUR CHILD EXPERIENCES WITH A BEE STING

A - Localized Swelling _____
B - Redness/Inflammation _____
C - Systemic Reaction Involving:
Shortness of Breath _____ Severe Itching _____ Extensive Hives _____
D - No Allergy to Bees _____

## TREATMENT REQUIRED:

A - Ice to Bee Sting _____
B - Call Home Immediately _____
C - Epipen _____
D - Beesting Kit _____
E - Oral Medication: _____ Yes _____ No
If Yes:
Medication Name _____
Dosage: _____
F - Call Ambulance _____

**NOTE:** If you checked "C","D", or "E", Please have your physician complete the bottom of this form if medication in any form must be administered. A parent note **must** accompany medication as well. Medication must be sent in to school with proper labeling.

## IF MEDICATION IS REQUIRED, PLEASE HAVE THE PHYSICIAN COMPLETE THE INFORMATION BELOW.

Student Name _____

Type of Reaction: _____

| MEDICATION | |
|---|---|
| DOSAGE | |
| ROUTE OF ADMINISTRATION | |

| MEDICATION | |
|---|---|
| DOSAGE | |
| ROUTE OF ADMINISTRATION | |

**If Epipen or Bee Sting Kit is to be used, please give specific instructions:** _____

_____

Physician Signature _____ Date _____