**School Bee or Insect Allergy Assessment Form**

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap to enter a date. |
| Student Name |  | Date of Birth |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |  | Click or tap here to enter text. |
| Parent/Guardian |  | Phone/Cell |  | Work |

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap here to enter text. |
| Health Care Provider (Name) treating bee allergy |  | Phone |

Do **you think** your 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 student reacted to?

Click or tap here to enter text.

How many times has your student had a reaction? Never  Once  More than once, please describe: When was the last reaction?

Click or tap here to enter text.

Are the reactions:  staying the same  getting worse  getting better

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

No  Yes, please describe:

Has your student ever received or used an epinephrine auto injector as treatment?  No  Yes, please describe:

Click or tap here to enter text.

**Triggers and Symptoms**

What are the signs and symptoms of your student’s allergic reaction? *(Be specific; include things your child might say.)*

Click or tap here to enter text.

**Treatment**

Does your student understand how to avoid getting a bee sting or insect bite?

No  Yes

What do you do at home if there is a reaction to a bee sting or insect bite?

Click or tap here to enter text.

What treatment or medication has your health care provider recommended or prescribed for an allergic reaction?

Click or tap here to enter text.

Have you used the treatment or medication?  No  Yes

Does your student know how to use the treatment or medication?

No  Yes

Please describe any side effects or problems your student had in using the prescribed treatment or medication.

Click or tap here to enter text.

**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.

How can we help your student manage their allergy at school?

Click or tap here to enter text.

**Other**

Is your student involved in school sponsored after school activities/sports?  No  Yes

If yes, please list:

**Is there anything else school staff should be aware of?**

Click or tap here to enter text.

**I give consent to share with the classroom that my child has a life-threatening insect or bee allergy.**

Yes

No

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap to enter a date. |
| Parent/Guardian Signature |  | Date |

|  |  |  |
| --- | --- | --- |
| Click or tap here to enter text. |  | Click or tap to enter a date. |
| Reviewed by RN |  | Date |

Adapted with permission from ESD 171 SNC Program