Bee/Insect Sting Information Form

Please provide the following information regarding your child's reaction/s to bee or other insect sting so that, should a sting occur at school, he/she will receive the necessary care.

Student _____Grade_____DOB_____

Approximate date of last sting:_____

My child has reaction/s to:

Bees

Wasps

Other Insects: _____

My child's bee/insect sting reaction includes:

Swelling, itching, rash ONLY in the area of the sting (e.g. stung in the arm and all symptoms happen to that arm only)

Generalized skin flush/blush, swelling, itching or rash in areas OTHER THAN the sting site (e.g. stung in the arm and had a rash over the chest and face)

Swelling of lips, nose, tongue or throat, hoarseness, breathing and/or swallowing difficulty. **If checked, please complete the Emergency Action Plan – Insect Sting form.**

The above symptoms began:

Within a few seconds to minutes

After 30 minutes or an hour

My child has been seen by a doctor for stings. Yes No

Results of doctor's visit: _____

_____

If my child is stung at school, he/she will be provided routine treatment including: attempt to remove stinger if present, ice, topical sting pain reducing application and observation for 10-15 minutes.

Additional care my child should receive:

Administer oral antihistamine medication (e.g. Benadryl , Zyrtec, etc.)

If checked, name of medication student is to be given: _____

Dosage to be given: _____

Please note: Medication must be brought to school for my child's use in the event of a sting.

Administer Epi Pen (or similar injectable epinephrine). **If checked, please complete the Emergency Action Plan – Insect Sting form.**

Additional care/treatment my child should receive if stung includes: _____

_____

Parent Signature: _____ Date: _____