Dear Parent of ____ Date _________________

You have indicated that your child has an allergy or reaction to bee stings. Please provide additional information by completing the form below. Since occasional bee stings do occur at school, it is important to be prepared to provide the appropriate care.

Thank you for your prompt response. Your child's health and well-being is very important to everyone here at school.

Sincerely,

School Nurse

My child's reaction to Bee-stings is best described as:

____ A **slight** swelling, redness and itching where he/she was stung.

____ A **large amount** (size of a baseball or larger) of swelling, redness and itching where he/she was stung.

____ A **severe allergy** to bee stings which may include (check which symptoms your child has had in the past)

	Mouth	Itching and swelling of the lips, tongue or mouth
	Throat	Itching and/or a sense of tightness in the throat, hoarseness, coughing
	Skin	Hives, itchy rash, and/or swelling about the face or extremities
	Gut	Nausea, abdominal cramps, vomiting, and/or diarrhea
	Lung	Shortness of breath, repetitive coughing, and/or wheezing
	Heart	"Thready" pulse, "passing out"
	Mental	Anxiety or feeling of impending doom

The treatment my child needs when stung by a bee is:

____ Ice applied to the sting

____ Benadryl or other Anti-histamine medication (given with order from licensed prescriber).

____ Epinephrine (Epi-Pen) (given with order from licensed prescriber).

____ Additional instructions or comments: ____
____

____ ___________________________
Parent/Guardian Signature Date

Please Note: All medications require a complete Request for the Administration of Medication at School form signed and dated by both the parents and doctor. Please refer to the schools medication policy for more information.