Assessment Form:
Insect Allergy

Easton Arts Academy
30 North 4th Street, Easton, Pennsylvania 18042
Phone (484) 546-4230 Fax (610) 829-6076

School: _____
Date: _____

Dear Parent/Guardian of _____

According to our health records, your student has a bee sting allergy. It would be helpful if you would provide us with information by answering the questions below and returning this form to the school nurse's office. Thank you.

Sincerely,

School Nurse: _____

Name of doctor treating student's bee sting allergy: _____
Phone: _____ Address: _____
Do you give permission for a member of our team to speak to the doctor? Yes/No
When did you become aware that you student was allergic to bee stings?
_____
Approximately when did you student last have a bee sting rection?
_____
Please describe how your student look and acted during the reaction:
_____
_____
_____
What medical treatment was provided and by whom?
_____
_____
_____
Does your student require any medications for bee sting reactions? Yes/No
If yes, please list medication, dosage, and frequency.
Medication:_____ Dose: _____ Frequency: _____
Medication:_____ Dose: _____ Frequency: _____
If you student is stung on the way to school or at school, what procedure would you like us to follow? _____
_____
_____
_____

Parent/Guardian Signature: _____ Date: _____

Thank you for your help!

School Nurse Office Use Only:
Date Received: _____
CC: Health File/Teacher Files/Parent or Guardian/Physican/Case Manager (if appicable)