



McHenry Elementary School District 15
1011 N. Green Street, McHenry, Illinois 60050
www.d15.org

Date: _____

BEE STING ALLERGY ASSESSMENT

According to your student's records, she/he has a bee sting allergy. Please provide us with more information by completing this form and returning it to the health office.

Student Name: _____ Date of Birth: _____
School: _____ Grade: _____ Teacher/Team: _____

CONTACT INFORMATION:

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____

MD/HEALTH CARE PROVIDER

Allergist/Physician Name: _____ Phone: _____
Address: _____ Fax: _____

Bee sting allergies are no longer a problem for my student. Sign below and return this form to the school Health Office.

When did you first become aware that your child was allergic to bee stings? _____

Approximately what was the date of your child's last bee sting reaction? _____

Please describe the signs and symptoms of the reaction: _____

What medical or first aid treatment is usually required? _____

If your child receives a bee sting on the way to school or while at school, what procedures would you like us to follow?

If your child will need an **Epi-Pen** for school use, please contact the school nurse for the required forms to be completed before the school can initiate medication administration. Feel free to call the Health Office if you have any questions or concerns.

Signature: _____ Date: _____
Parent/Guardian

Signature: _____ Date: _____
Nurse