ELLWOOD CITY AREA SCHOOL DISTRICT

501 CRESCENT AVE. ELLWOOD CITY, PA 16117
PHONE: (724)752-1591 FAX: (724)758-0534

BEE STING ALLERGY FORM

Student:	Grade/Class:
When was your child last stung?	

What symptoms occur when your child is experiencing a reaction:		
( ) hives	( ) difficulty breathing	( ) local swelling
( ) other:		

What treatment will your child need if they are stung at school:		
( ) ice application	( ) Transfer to ER	( ) other:
( ) medication, please list name and dose:		

IF YOUR CHILD NEEDS MEDICATION FOR A BEE STING, YOU WILL NEED TO SUPPLY THE MEDICATION AND NECESSARY FORMS WHICH CAN BE OBTAINED FROM THE SCHOOL HEALTH OFFICE.	
Parent Signature:	Date:

PLEASE FEEL FREE TO USE THE BACK OF THIS FORM TO SUPPLY ANY OTHER ADDITIONAL INFORMATION THAT YOU FEEL WOULD HELP US TO MANAGE YOUR CHILD'S BEE STING ALLERGY AT SCHOOL. THANK YOU

ADDITIONAL BEE STING INFORMATION FOR:

Parent Signature:	**Date:**