

**ST. MARY'S COUNTY PUBLIC SCHOOLS**  
*Department of Student Services/ St. Mary's County Health Department*

*INSECT ALLERGY INFORMATION*

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergic to: \_\_\_\_\_

Diagnosed by Doctor:  Yes  No Doctor's Name: \_\_\_\_\_

Date of Last Allergic Reaction: \_\_\_\_\_

1. Do you consider the insect allergy to be life threatening to your child?  Yes  No

**If Yes, an Insect Allergy Emergency Action Plan may be needed at school.**

2. Please list the type of insect allergy: \_\_\_\_\_

3. Please list any daily or as needed medications your child takes.

	Name of Medication	Dose	Frequency
(In School)	_____	_____	_____
	_____	_____	_____

**If medication is needed at school, please have your doctor complete a Medication Authorization form.**

(At Home) \_\_\_\_\_  
\_\_\_\_\_

4. Does your child have a prescribed EpiPen for emergency use?  Yes  No
5. Please check only those symptoms which you have observed when your child has had an allergic insect reaction:
- |  |  |
|--|--|
| <input type="checkbox"/> itching or swelling of lips, tongue, or mouth   | <input type="checkbox"/> swelling about the face or extremities                          |
| <input type="checkbox"/> nasal congestion                                | <input type="checkbox"/> difficulty breathing, shortness of breath or wheezing           |
| <input type="checkbox"/> runny nose, sneezing, or sniffing               | <input type="checkbox"/> difficulty swallowing or choking                                |
| <input type="checkbox"/> itching or sense of tightness in the throat     | <input type="checkbox"/> repetitive coughing   |
| <input type="checkbox"/> sore throat or throat clearing, "hacking" cough | <input type="checkbox"/> dizziness or fainting   |
| <input type="checkbox"/> hoarseness                                      | <input type="checkbox"/> shock (fall in blood pressure and increased thready pulse rate) |
| <input type="checkbox"/> nausea or vomiting                              | <input type="checkbox"/> unconsciousness   |
| <input type="checkbox"/> abdominal cramps or diarrhea                    | <input type="checkbox"/> other _____   |
| <input type="checkbox"/> hives   |  |
6. Progression of symptoms were: (Please check.)
- increasing and worsening rapidly
- early, mild symptoms with apparent resolution followed by rapid development of lung and/or heart symptoms
- other \_\_\_\_\_
7. How long after being exposed to the allergen did your child develop symptoms? (Please check.)
- immediately
- within 15 – 20 minutes
- within an hour
- longer than one hour (specify time) \_\_\_\_\_
8. Has your child ever been hospitalized (emergency room) for an allergic reaction?
- Yes  No
9. Does your child know to avoid the allergen?  Yes  No

Parents'/Legal Guardians' Signature \_\_\_\_\_ Date \_\_\_\_\_