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:
   ☐ itching or swelling of lips, tongue, or mouth
   ☐ nasal congestion
   ☐ runny nose, sneezing, or sniffing
   ☐ itching or sense of tightness in the throat
   ☐ sore throat or throat clearing, “hacking” cough
   ☐ hoarseness
   ☐ nausea or vomiting
   ☐ abdominal cramps or diarrhea
   ☐ hives
   ☐ swelling about the face or extremities
   ☐ difficulty breathing, shortness of breath or wheezing
   ☐ difficulty swallowing or choking
   ☐ repetitive coughing
   ☐ dizziness or fainting
   ☐ shock (fall in blood pressure and increased thready pulse rate)
   ☐ unconsciousness
   ☐ other _______________________________

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 ___________________________

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