

West Carroll Community Unit School District 314

BEE OR WASP STING INFORMATION

Date _____

School _____

Dear Parent or Guardian:

Current health information we have for your child _____ indicates a history of reactions to bee or wasp stings. Please read and check appropriate statements listed below to provide the school personnel with a better understanding of previous reactions and recommended first aid.

A. Symptoms of prior reactions

- 1. Redness and swelling in area of sting
- 2. Rash or hives over most of the body
- 3. Wheezing and/or difficulty breathing
- 4. Nausea and/or vomiting
- 5. Unconsciousness and/or shock
- 6. Other symptoms _____

B. Was medical care necessary when child was previously stung?

Yes No

What medical care should be given?

- 1. Cold compress and/or OTC topical hydrocortisone cream
- 2. Oral medication [parent provides]
- 3. Injections [doctor prescribes, parent provides]
- 4. Treatment in doctor's office [parent provides]
- 5. EMS transport to hospital

C. Is your child presently receiving [or has he received] injections to desensitize him against future reactions?

Yes No

D. Does your child wear an identifying tag or bracelet alerting others to possible reactions to bee or wasp stings?

Yes No

E. Medications provided to the nurse? Yes No

West Carroll's routine beesting treatments include OTC topical anesthetic, hydrocortisone cream and/or an ice pack, UNLESS OTHERWISE SPECIFIED by you [or your physician], and any necessary medication needs to be supplied by you to the school on an annual basis. Please return this form to your child's school health office.

Signature of Parent or Guardian

Date