Cowichan Valley School District

Form 316-06

School _____

Teacher _____

Grade _____

INSECT ALLERGY

Student's Name:		Birth Date:	
Mother's Name:		Home Phone #	Work/Cell Phone #
Father's Name:		Home Phone #	Work/Cell Phone #
Emergency Contact 1	Relationship	Home Phone #	Work/Cell Phone #
Emergency Contact 2	Relationship	Home Phone #	Work/Cell Phone #
Doctor's Name:		Phone #	Clinic location

Please tick (✓) all that apply:

Previous Reactions	**Previous Treatment Given:**	
☐ Pain, swelling, itching, warmth at the sting site…disappears in a few hours	☐ Ice and "Stingstop" or..	
☐ Swelling and tenderness of an entire limb…lasts up to a week	☐ Antihistamine: Type: Dose:	
☐ Sneezing, itching, hives, swelling, anxiety, fainting		
☐ Abdominal pain, nausea, vomiting	☐ Anakit	☐ Epipen
☐ Tightness of the throat, shortness of breath, cough	☐ Hospitalization	
☐ Other, specify	☐ Other, specify	

Time of Reaction:

☐ Immediately

☐ Within 10 minutes

☐ After 10 minutes… please explain _____

_____

What emergency care do you expect your child to receive if they are stung at school?

_____

_____

Does your child wear a Medic Alert bracelet? ☐ Yes ☐ No

_____ _____

(Parent/Legal Guardian Signature (Date)

IF YOUR CHILD WILL NEED MEDICATION, PLEASE GET THE APPROPRIATE FORM FROM THE SCHOOL