



# Winton School District

7000 N Center Street

P.O. Box 8

Winton, CA 95388-0008

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*EEO Affirmative Action Employer*

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Randall W. Heller

Date: \_\_\_\_\_

Dear Parent/Guardian:

I understand that your child, \_\_\_\_\_ DOB: \_\_\_\_\_ might be allergic to bee/insect stings. This is a critical problem for some of our students and I am concerned about the extent to which it is significant for your child. The following information would be greatly appreciated:

Yes No 1. Does your child have problems with bee/insect stings at the present time?

- If you answer **No**, please sign and return this form to the school nurse.
- If you answer **Yes**, please complete questions 2 through 7, sign and return this form to the school nurse .

Yes No 2. Has swelling been limited to the area around the bee/insect sting?

Yes No 3. Has he/she ever had difficulty breathing as a result of a bee/insect sting?

Yes No 4. Does he/she have oral or injectable medication at home to be taken in case he/she is stung?

Yes No 5. Should he/she carry oral medication with hem/her?

Yes No 6. Does his/her reaction require that an injectable medication be given immediately if he/she is stung?

Yes No 7. If your child takes oral medication or injections, do you wish to leave a prescription at school in the event he/she is stung?

State law does allow a student to carry injectable medication if there is parent and physician consent. If you would like to have medication stored at the school if you would like your child to carry his/her medication, please contact the school nurse in order to obtain the necessary consent forms.

Name of Family Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Phone: \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
District School Nurse