CHICO UNIFIED SCHOOL DISTRICT
1163 East Seventh Street
Chico, California 95928
(530) _____

Dear Parent:

I understand that your child, _____, might be allergic to bee 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.

_____ _____
Date School Nurse/Health Aide

1. Does your child have problems with bee/insect stings at the present time? 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 take in case he /she is stung? Yes____ No____

5. If your child takes oral medication or injections, do you plan to provide a prescription to be kept at school in the event he/she is stung? Yes____ No____

Parent/Guardian Signature _____ **Date** _____

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IF YOUR CHILD NEEDS MEDICATION FOR BEE STING REACTIONS, COMPLETE AND RETURN THIS FORM TO SCHOOL. SUCH MEDICATION IS TO BE PROVIDED BY THE PARENT IN THE ORIGINAL CONTAINER WHICH INDICATES THE CHILD'S NAME. IT WILL BE KEPT IN THE SCHOOL HEALTH OFFICE. THIS FORM MUST ACCOMPANY THE MEDICATION AND BE SIGNED BY THE PARENT AND THE PHYSICIAN.

Section 117531 Education Code, Medications During School, says: "Provides that pupil required to take, during regular school days, medications prescribed by a physician may be assisted by the school nurse or other designated school personnel if the school district receives specified written statements from such physician and the parent or guardian of the pupil."

Child's Name: _____ Birthdate _____

Medication to be administered: _____

Dosage: _____

Anticipated normal reactions to medication: _____

_____ _____ _____
Doctor's Signature Date Doctor's Telephone Number

Referring to the above-named student, I hereby request and authorize the exchange of medical information in your possession with Chico Unified School District personnel authorized to receive such information.

I approve of this authorization for medication to be given to my child by school personnel as indicated by my physician on this medication order form.

Parent/Guardian Signature_____ **Date** _____