



TOMS RIVER REGIONAL SCHOOLS

STUDENT'S NAME: _____

GRADE: _____

DATE: _____

Dear Parent/Guardian:

In reviewing your child's health information, it was noted that he/she has allergic reactions to bee sting/insect bites. To better serve the health needs of your child, please briefly answer the questions listed.

What type of reaction does your child experience? (ex: Localized reaction or generalized reaction)

When was your child's last allergic reaction?

Does your child need medication for this reaction?

Yes _____ No _____

Does your child's physician suggest that this medication be available during school hours? If so, please complete the District's Medication Policy.

Sincerely,

Nurse (s)

Signature of Parent/Guardian: _____

Cell #: _____

Work #: _____