Campus: _____ **Date:** _____

BEEVILLE
INDEPENDENT SCHOOL DISTRICT
INSPIRING BOLD INNOVATIVE LEADERS

Health Data Collection Form – ANAPHYLAXIS

(To be completed by parents and school nurse)

Student Name: _____ **Date of Birth:** _____ **Grade:** ____ **Student ID:** _____

What is your child Allergic to (list all medications, environmental, and food): _____

_____

_____

Emergency Contacts:

Mother/guardian name:_____

Work Number: _____ Cell Number: _____

Father/Guardian name: _____

Work Number: _____ Cell Number: _____

Other Name, phone number and relation: _____

_____

Physicians:

Pediatrician: _____ Phone Number: _____

Specialist: _____ Phone Number: _____

Last Hospital Admission date: _____ Hospital name: _____

Medical Diagnosis (list all health diagnosis for child): _____

_____

Medications (list all medications given at home and at school): _____

_____

_____

Has your child had a severe anaphylactic reaction in the past: ___No ___ Yes→ Date: _____

Name of treating hospital: _____

What are signs of an allergic reaction in this student (check all that apply):

___ Drooling	___ Swollen eyes	___ Hives
___ Runny nose	___ Watery eyes	___ Rash
___ Wheezing	___ Vomiting	___ Itching
___ Rapid heart rate	___ Cough	___ C/O tongue or throat swelling

Other: _____

❖ *Epi-pen emergency medication ordered: ___NO____YES ↓*

Date it was last administered: _____

Allergy and Anaphylaxis Emergency Plan from Physician: ___ NO _____ Yes→ Date of plan: _____

Parent Authorization Request for Medication Administration forms provided: ___Yes ___No

(Form may be picked up at school or downloaded from BISD website, must be signed by parent and physician)

Is parent/guardian signature on Form _____

EPI PEN ORDER (if applicable):

Brand name: _____ Dosage: _____

Does the prescription order match the prescription label? _____

Expiration Date of medication (look on the epi pen auto-injector): _____

When to administer Epi-pen: _____

Where will Epi-pen be stored: _____

Who will administer Epi-pen in nurse's absence: _____

(Principal designee. To be completed by campus nurse)

Physical activity restrictions: _____

Assistive devices (ex: glasses, hearing aides, wheelchair, braces, walker): _____

_____

_____

Does the student need any special assistance: _____

_____

_____

Additional Information: _____

_____

_____

Data collected by: _____ Date: _____

(Parent/Guardian Signature)

Reviewed by: _____ Date: _____

(School Nurse Signature)