Campus: _____ Date: _____

BEEVILLE
INDEPENDENT SCHOOL DISTRICT
INSPIRING BOLD INNOVATIVE LEADERS

HEALTH DATA COLLECTION FORM – SEIZURES

(To be completed by parent and school nurse)

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

Does your child have any allergies (food, medication, environment): _____
_____

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): _____
_____
_____

Age when student had first seizure: _____ Type of seizures: _____

Date of Last Seizure: _____ Was your child hospitalized: ___Yes ___No
Last Hospitalization Date: _____ Name of Hospital: _____

Describe your child's seizures: _____
_____
_____
_____

How long do seizures last: _____
How often do seizures occur: _____
Any known triggers or auras: _____
How does the student typically act after a seizure has occurred: _____
_____
_____

Diastat Medication ordered: ___NO ___Yes→ Expiration date: _____ Green Ready Band? _____

Has Diastat ever been given before: ___NO ___Yes → Date Diastat last given? _____

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)

Completed forms returned from parents to nurse: ___Yes ___No

Is parent/guardian signature on Form _____

DIASTAT Order (if applicable):

Dosage: _____

When to administer Diastat: _____

Where will Diastat be stored: _____

Current Physician ordered Seizure Action Plan in place (obtain from physician and provide complete and signed copy to school nurse): _____Yes _____ No Date of action Plan (new plan required yearly): **_____**

Has the doctor ordered a special diet for your child: _____

Physical activity restrictions: _____

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

Does your child need any special assistance: _____
_____
_____

Additional Information: _____
_____
_____

Physicians:

Pediatrician: _____ Phone Number: _____
Neurologist: _____ Phone Number: _____
Hospital Preference: _____ Phone Number: _____

Data collected by: _____ Date: _____
(Parent/Guardian Signature)

Reviewed by: _____ Date: _____
(School Nurse Signature)