

School Year: _____ - _____



Place student's picture here

**MEDICAL FORM: CARDIAC CONDITION
(EMERGENCY CARE PLAN/MEDICAL 504)**

Student's Name:		Date of Birth:	
School:	Teacher:	Grade:	
Transportation:	School bus	Walks	Other:
Brief history of diagnosis:			
Concurrent illness/disability:		Recent hospitalizations:	
Medication at home:			
Medication at school (<i>medication authorization form must be on file</i>):			

Health Care Provider Complete: Please indicate if this condition is life threatening:

- No**, this condition is not life threatening. No intervention is needed at this time. **(Please sign back page)**
- Yes, this is a life threatening condition.** A medication/treatment plan is needed. **(Continue below)**

Treatment at school, unless otherwise indicated by Health Care Provider:

GOLDEN RULE: IF found unconscious/ unresponsive, initiate CPR/use Automated External Defibrillator (AED), CALL 911

If you see the following:	What to do:
Dizziness/ feeling faint	<ul style="list-style-type: none"> • Have student lie down and elevate legs • Attempt to check heart rate _____ • If symptoms persist (still dizzy lying/ cannot sit up) – CALL 911 • If symptoms improve (no longer dizzy when sitting up) offer fluids and call parents
Palpitations (rapid/ irregular heart beat)	<ul style="list-style-type: none"> • Use calming approach • Reassure student • Attempt to check heart rate • If symptoms persist (palpitations continue despite above) call 911 • If symptoms improve call parents
Chest pain	<ul style="list-style-type: none"> • Use calming approach • Have patient lie down • If severe and having dizziness or shortness of breath associated with chest pain, call 911 • If moderate and persists longer than 10 minutes, call 911 • Notify parents
Bleeding/severe bruising (for patients on anticoagulant therapy)	<ul style="list-style-type: none"> • Notify parents immediately • If patient experiences injury to head/ abdomen, complaints of back/belly pain, or coughing/urinating/vomiting blood: CALL 911 • Form minor cuts/light bleeding, provide basic first aid
Additional symptom/concern: _____	<ul style="list-style-type: none"> • Instruction • : _____

Classroom Information/ Accommodations:

- No Yes Go outside during regular recess periods & walk, run, play at own pace as tolerated.
 - No Yes Remain inside during severe cold weather. Specify temp: _____
 - No Yes Remain in the shade when temperature is over 90 degrees.
 - No Yes Participate in regular P.E.
 - No Yes Participate in competitive or contact sports.
 - No Yes Participate in a group run, less than _____ miles.
 - No Yes Permit student to rest, sit, squat, or lie down, whenever necessary.
 - No Yes Bathroom access as needed
 - No Yes Dietary restrictions: _____
- Other: _____

Field Trip Accommodations (as needed) - Medications/supplies are taken and care is provided (Mark one):

- By accompanying parent
By the student, if self - managing
- By accompanying designated school staff per district medication policies/orders

Extra-Curricular Activities Accommodations (as needed)- Medications/supplies are taken and care is provided (Mark one):

- By accompanying parent
- By the student, if self - managing
- By accompanying designated school staff per district medication policies/orders

Disaster Planning: _____

Health Care Provider Signature:		Date:
Health Care Provider Name (print/type):		
Phone:	Fax:	Address:

Parent/Guardian Contact Information:

Name: _____ Ph: Home _____ Cell _____ Work _____

Name: _____ Ph: Home _____ Cell _____ Work _____

EMERGENCY CONTACTS (if unable to reach parent/guardian):

Name: _____ Relationship: _____ Ph: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____ Ph: _____

PARENT/GUARDIAN CONSENT for 504 Health Care Plan:

- I understand that a 504 meeting with the school nurse must occur. I request to have this meeting:
(please initial one) _____ via telephone OR _____ in person, at school [Office Use: Date of 504 Mtg ___/___/___]
- I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I consent for my child to be evaluated for a health care plan/medical 504 plan. I have received a copy of the Notice of Parent/Student Rights under Section 504 (Form 504-1). I agree with this health care plan/medical 504, consent for the placement outlined, and request designated school personnel to follow this plan as it is written. I understand that if I disagree with this plan, I have the right to request a hearing by filing a written request using the 504-7 form. I understand that this health care plan/medical 504, including the medical treatment/medication orders provided, must be renewed and reviewed annually. I understand that my child will be reevaluated every three years to determine if my child continues to qualify for a school health care plan/medical 504.
- I give health services staff permission to communicate with the LHCP's office about any medical treatment/medication orders that I provide to the school, in accordance with HIPPA/FERPA regulations. I understand the school may share this plan with emergency responders if student requires services.
- If medication is prescribed within this plan, the medication is to be furnished by me in the original container, and BROUGHT TO SCHOOL BY AN ADULT. Prescription medication must be labeled by the pharmacy with the name of the patient, health care provider, medication, dosage, and the time of day to be given. I understand medication may be administered by non-licensed trained designated staff members in accordance with state regulations and district policy. I understand that at the end of the school year, an adult must pick up any medication, otherwise it will be discarded.

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by school Nurse: _____ **Date:** _____

**RICHLAND SCHOOL DISTRICT NOTICE OF PARENT/STUDENT RIGHTS
UNDER SECTION 504
(Form 504-1)**

The Rehabilitation Act of 1973 ("Act"), commonly referred to as "Section 504," is a non-discrimination statute enacted by the United States Congress. The purpose of the Act is to prohibit discrimination and to assure that disabled students have educational opportunities and benefits equal to those provided to non-disabled students.

This is a notice of your rights under Section 504. This document is not intended to address the rights afforded under the Individuals with Disabilities Education Act ("IDEA") that applies to students eligible for special education services. The Office of the Superintendent of Public Instruction's ("OSPI") Notice of Special Education Procedural Safeguards for Students and Their Families is available through the District's Special Education Department and sets out the rights assured by the IDEA. It is the purpose of this notice to set out the rights assured by Section 504 to those disabled students who have a physical or mental impairment that substantially limits one or more major life activity who do not qualify under the IDEA.

Federal laws and regulations provide parent(s)/guardian(s) and students with the following rights:

1. You have the right to be informed by the District of your rights under Section 504 (the purpose of this notice is to advise you of those rights).
2. You have the right to have your child participate in and benefit from the District's education program without discrimination based on disability.
3. You have the right to receive notice before the District takes any action regarding the identification, evaluation, and/or placement of your child.
4. Your child has a right to an evaluation prior to an initial Section 504 placement and any subsequent significant change in placement. You have the right to refuse consent for the initial evaluation and initial placement of your child.
5. You have the right to have your child receive a free appropriate public education ("FAPE"). This includes your child's right to be educated with non-disabled students to the maximum extent appropriate. It also includes the right to have the District provide related aids and/or services to allow your child an equal opportunity to participate in school activities, educational, and/or related aids and services provided to your child without cost except for those fees imposed on the parent(s)/guardian(s) of non-disabled children.
6. Your child has a right to facilities, services, and/or activities that are comparable to those provided for non-disabled students.
7. You have the right to have evaluation, educational, and/or placement decisions for your child based upon information from a variety of sources, by a group of persons who know your child, your child's evaluation data, and/or placement options.
8. You have the right to have your child be provided an equal opportunity to participate in non-academic and extracurricular activities offered by the District.

9. You have the right to examine your child's education records and obtain a copy of such records. You also have the right to receive a response to reasonable requests for explanations and interpretations of your child's education records.
10. You have the right to request the District to amend your child's education records if you believe that they are inaccurate, misleading, and/or otherwise in violation of the privacy rights of your child. If the District refuses this request, you have the right to challenge such refusal under the Family Educational Rights and Privacy Act ("FERPA").
11. You have the right to request mediation or an impartial hearing with respect to the District's actions regarding your child's identification, evaluation, and/or educational placement with opportunity for parental participation in the hearing and representation by an attorney.
12. If you wish to challenge the actions of the District in regard to your child's identification, evaluation, and/or education placement, you should file a written request for a hearing with Mike Hansen, Student Section 504 Program Coordinator, 615 Snow Ave, Richland, Washington 99352; email to: mike.hansen@rsd.edu using the Request for a Hearing (Form 504-2). A hearing will be scheduled before an impartial hearing officer and you will be notified in writing of the date, time, and place of the hearing.
13. If you disagree with the decision of the impartial hearing officer, you have a right to review that decision by a court of competent jurisdiction. If you prevail in a civil rights action against the District, you have the right to seek the payment of reasonable attorney's fees through the court.
14. You have the right to file a local grievance or complaint with the U.S. Department of Education's Office for Civil Rights or file a complaint in federal court. The address of the Regional Office that covers Richland:

U.S. Department of Education Office of Civil Rights
915 Second Avenue, Room 3310
Seattle, Washington 98174-1099
Phone: (206) 607-1600
Website: www.ed.gov/OCR
Email Address: OCR.seattle@ed.gov