Hemophilia Documentation

Completed by Health Care Provider

Student Photo

Name: Birth Date:

Hemophilia program/Numbers:

Diagnosis:_____

Brief description of condition:_____

_____

How would this current condition adversely affect student's educational performance?_____

_____

Medication and dosage:_____

_____

Possible side effects of medication that school personnel need to be aware of:_____

_____

Symptoms:

Internal bleeding	**Child reports having a joint bleed; c/o tingling, bubbling pain, stiffness, or decreased motion in any limb; part of the body (usually joint) swollen or hot to the touch; appears to be favoring an arm or leg more than usual; limps or refuses to use a limb; may have no history. Complains of abdominal pain, severe headache or fever.**

Give first aid as you would with any other child for minor external bleeding, typical nose bleed, laceration requiring stitches: apply direct pressure and ice for 5 to 20 minutes

Action Plan: If sending student with a blow to head, neck, or abdomen, send with an escort

If s/s of internal minor bleeding	**If oozing from a cut in the mouth or around a tooth**	**If blow to the head, neck or abdomen**
• Contact parent for instructions • While waiting for parents keep child still to avoid further injury • Apply ice and elevate the affected body part	• Put on gloves • Apply ice compress w/firm, continuous pressure for 20 minutes • Wet tea bag applied around tooth • No response, call parent	• Contact parents immediately • If unable to reach parents, call hemophilia center or child's MD • If neither the MD, nurse or parents can be reached, call 911

Further recommendations from HCP: ***(classroom, school bus, field trips, disaster etc.)***

Classroom Information/Accommodations (as needed):

- Bruising common

***Store factor at school for parental use or to go with 911 responders if needed yes no**

Health Care Provider Signature:	Date:
Health Care Provider name (print or type)	
Phone:	Fax:
School Nurse Signature:	Date:

Date Reviewed with Parent (To be updated at least every 3 years)

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature

AUTHORIZATION FOR MUTUAL RELEASE OF RECORDS

Kennewick School District Nursing Services

Purpose: *As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Right and Privacy Act. FERPA, (for example, transfer of records from one school district to another).*

Student Name: _____ Date: _____ DOB: _____

I hereby authorize the release of records

From:		***To:***	
Agency/Person:		**Agency/Person:** ***KSD Nurse***	
Street Address:		**Street Address:**	
City, State, Zip:		**City, State, Zip:** ***Kennewick, WA,***	
Tel:	***Fax:***	***Tel: 509-222-***	***Fax: 509-222-***

Describe the records to be disclosed: Diagnoses, medication and any medical recommendations that are applicable for the student at school.

The reason for disclosing the record(s) is: To provide safe care of the student in the educational setting.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from _____/_____/_____ **to** _____/_____/_____**.**

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian/student signature Date