Seizure Disorder Documentation

Completed by Health Care Provider

Student Photo

Name:	Birth Date:

Diagnosis/SeizureType:_____Last known seizure:_____

Date of last EEG_____Results_____

Brief description of condition:_____

Medication and dosage:_____

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

How often do seizures occur?_____

Behavior **before** Seizure/ Triggers/ time of day:_____

Behavior **during** Seizure: (what happens, duration)_____

_____

Behavior **after** Seizure:_____

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

_____

Action Plan: If sending student who is possibly going to have a seizure, send with escort

Basic Seizure Management	**Call 911 if:**
• Stay calm & stay with student • Note time of onset of seizure • Help to the ground if loss of consciousness and turn student on side. Protect the head. • Do not restrain student • Do not put anything in their mouth. • Send for help • Have office staff contact parent • Have student rest after seizure until transport arrives.	• Student turns blue and/or stops breathing (Begin CPR if not breathing) • Seizure lasts longer than 5 minutes. • Student has a series of seizures. • Student requests to be transported.

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

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