SAN MATEO-FOSTER CITY SCHOOL DISTRICT

LIVE • LEAD • LEARN

School Year: 2024 - 2025

Dear Parent/Guardian,

Keeping students safe and healthy at school continues to be the goal of the San Mateo-Foster City School District's Nursing Department. We appreciate your help in assisting us in that effort and we look forward to seeing your student at school in August.

Supporting students diagnosed with seizure disorders continues to be a priority and we appreciate your help in assisting us in that effort. Thank you for taking a moment to review the attached Seizure Packet.

Please have your child's medical team complete and return the attached Seizure Packet. Also, be sure to include your child's most recent doctor's orders and return your paperwork as soon as possible or by August 9, 2024.

Thank you for your assistance and please let me know if you have any questions.

I look forward to working with you this year.

Sincerely,
Student Services
SM-FC Nursing Department

1170 Chess Drive
Foster City, California 94404
Tel: 650-312-7295
Fax: 650-655-3394

1170 Chess Drive
Foster City, California 94404
650.312.7700 Tel
650.655.3394 Fax
www.smfcsd.net

SAN MATEO – FOSTER CITY SCHOOL DISTRICT
STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION

Student/Parent Information

Name: _____ DOB: _____
Home Address: _____
Information to be Released From: _____
Agency/Person: _____
Address: _____
Phone Number: _____ Fax: _____
Information to be Released to and Used By:
Agency: San Mateo – Foster City School District Attention: _____
Address:
Phone: _____ Fax: _____

Purpose of Requested Information

- ☐ Release of health info at the request of student's parent, guardian or legal representative
- ☐ Provide and plan educational services for student
- ☐ Other: _____

Records: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **MEDICAL SUMMARY** _____ (initial)
- ☐ **PHYSICAL EXAM**
- ☐ **PSYCHIATRIC RECORDS**
- ☐ **IMMUNIZATION RECORDS**
- ☐ **LAB/X-RAY/TEST RESULTS**
- ☐ **VERBAL EXCHANGE**
- ☐ **OTHER HEALTH INFORMATION**

Signature	Date

Specify the records to be disclosed: _____

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date)

REVOCATION: This authorization is also subject to written revocation by the parent/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A copy of this authorization is as valid as the original. Parent/Guardian has a right to a copy of this authorization.

_____ _____
Signature **Date**

SAN MATEO – FOSTER CITY SCHOOL DISTRICT
1170 Chess Drive | Foster City, CA 94404
PHONE (650) 312-7700 FAX (650) 655-3387

SEIZURE PROTOCOL AND INFORMATION FORM

School_____ Teacher_____ School Year_____

Student's Name_____ Date of Birth_____

Type of Seizure_____ Length_____ Frequency_____

Seizure Symptoms_____

Last Seizure _____Warning Signs/Triggers _____

Please have student's prescribing physician fill out information below:

Medication_____ Dosage_____ Route_____

Administration Instructions_____

Physician_____ Address_____

Phone number _____Fax _____

Physician's Signature _____Date_____

Parent/Guardian_____
Phone: _____ Cell: _____

Emergency Contacts_____

Phone_____ Cell_____

Parent/Guardian Signature_____

Date_____

Clinical Stamp Here

School Protocols:

1. Ease student to floor. Protect student from any sharp objects. Students in wheelchairs should stay in their chairs.
2. DO NOT put anything into the student's mouth.
3. If possible, safely position student on their side to keep airway open and to drain secretions
4. Note the time. Observe and record what the seizure looks like and how long it lasts.
5. Check skin color and monitor respirations throughout the seizure.
6. Call parent/guardian and District Nurses to inform them of the seizure.

911 WILL BE CALLED IF:

1. Student is injured, or is diabetic
2. The seizure continues after five minutes or a cluster of repeated seizures without regaining consciousness
3. At any time during the seizure, the student turns blue or has difficulty breathing
4. School staff assesses the student is in danger.
5. School staff will call the parent/guardian, the main office and the District Nurse.
6. School personnel will follow the student if taken by ambulance.

SAN MATEO-FOSTER CITY SCHOOL DISTRICT
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Students Name: _____Birthdate: _____

Teacher: _____Grade: _____

School: _____School Year: _____

PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

TO BE COMPLETED BY PHYSICIAN OR OTHER HEALTHCARE PROVIDER LICENSED BY THE STATE OF CALIFORNIA TO PRESCRIBE MEDICATION.

STUDENT NAME (PRINT):_____

DIAGNOSIS FOR WHICH THE MEDICATION IS PRESCRIBED: _____

MEDICATION NAME: _____

Dosage: _____ Time: _____ Route: _____

IF DOSAGE IS AS NEEDED (PRN), THE SYMPTOMS THAT NECESSITATE ADMINISTRATION AND ALLOWABLE FREQUENCY: _____

_____

ESTIMATED TERMINATION DATE: _____

POSSIBLE SIDE EFFECTS: _____

_____

The child named above is under my care. It is necessary for him or her to receive the above-prescribed medication during school hours. The medication may be administered by trained, nonmedical school employees, under the supervision of the school nurse. The school nurse may not be present during administration of the medication.

DATE: _____ PHYSICIAN: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

PHYSICIAN SIGNATURE: _____

PHYSICIAN/CLINIC STAMP: _____

_____

I hereby give permission for school personnel to administer medication to my child during the school day as prescribed by the child's physician.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

IN CASE OF EMERGENCY, PHONE NUMBER I CAN BE REACHED AT: _____

SAN MATEO-FOSTER CITY SCHOOL DISTRICT
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PARENT AUTHORIZATION AND RELEASE FOR THE ADMINISTRATION OF MEDICATION AT SCHOOL

California Education Code Section 49423 allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day, provided that appropriate authorization is given.

"Medication" includes prescription medication, over-the-counter medication, nutritional supplements and herbal remedies. Parents are responsible for providing all medication and supplies and equipment necessary to administer the medication. No medications, including over-the-counter medications, will be given without a prescription. The medication prescription must be current and medication must be supplied in the original package or original prescription bottle with pharmacy label attached (ask your pharmacist to divide the medication into two bottles completely labeled: one for home and one for school). The medication must be prescribed to the student to whom it will be administered and all medication containers must include a label with the student's name, physician's name, the name of the medication, and directions for use.

I authorize and hereby request that designated school personnel assist my child in taking this prescribed medication (including prescribed over-the-counter medication, nutritional supplements and herbal remedies) as prescribed by the child's health care provider. I agree to, and do hereby release and hold the District and its employees and contractors harmless from any and all claims, demands, causes of action, liability or loss of any type, because of or arising from acts or omissions with respect to this medication and agree to indemnify each of them with regard to any judgment or claim rendered against them arising out of this medication administration arrangement. I understand that my child may not have or take medication at school unless all requirements are met. I hereby give consent for a school nurse to communicate with my child's health care provider and counsel school personnel as needed with regard to this medication.

_____	M/F	_____
Students Name (Print)	**SEX**	**Date of Birth**

I have read and understand the above authorization and release. I will immediately notify the school if there is any change in medication my child is taking at school. I understand that this authorization is in effect for a maximum of one school year, and the District will require a new authorization the beginning of each school year, or if any changes in prescription occur.

_____	_____
Signature of Parent or Legal Guardian	Date