

Individual Health Plan Sch year____ GR____ RM____
Seizure Disorder- Medication at School
Completed by Health Care Provider (Needs to be updated each school year)

Name:

Birth Date:

Diagnosis/Seizure Type: _____ Last know seizure: _____

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

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

Behavior **after** Seizure: _____

Medication and dosage taken at home: _____

EMERGENCY MEDICATION NEEDED AT SCHOOL: YES ☐ NO ☐ if yes please complete med form below:

Name of Medication(s) needed at school	Dose	When to give emergency med

Action Plan: If sending student having breakthrough seizures anywhere, send with escort

Basic Management	Call 911 if:
<ul style="list-style-type: none">• 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 in nurse's room after seizure is over	<ul style="list-style-type: none">• Student turns blue and/or stops breathing (Begin CPR if not breathing)• Seizure lasts longer than _____ minutes• The student has a series of seizures• The student requests to be transported• Emergency medication is administered by district staff.• ONLY LICENSED NURSE MAY GIVE RECTAL MEDICATION/MIDAZOLAM. NO NURSE TO ADMINISTER - CALL 911

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

Health Care Provider Signature:

Date:

Health Care Provider name (print or type):

Phone:

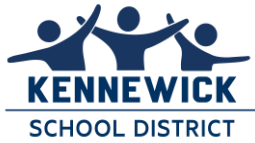
Fax:

School Nurse Signature: _____ **Date:** _____

Parent Permission (to be completed by parent or guardian)

- By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the administration of medication by the KSD staff or as self-administered by the student.
- Parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication.

PARENT/GUARDIAN SIGNATURE _____ DATE: _____



AUTHORIZATION FOR MUTUAL RELEASE OF RECORDS

Kennewick School District Nursing Services

MEDICATION AT SCHOOL RULES

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed oral, nasal spray, topical, eye drop or ear drop medication and over-the-counter oral, nasal spray, topical, eye drop or ear drop medication should be dispensed before and/or after school hours under supervision of the parent/guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed health care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

Authorization for Mutual Exchange of Confidential Information

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 records to be disclosed: Diagnoses, medication, medical recommendations applicable for student at school.

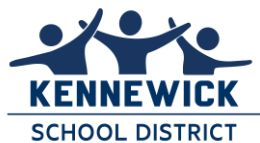
The reason for disclosing the record(s) is: To provide safe care of the student in the educational setting

This authorization is valid from: ____/____/____ to: ____/____/____.

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).

I understand 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: _____
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Kennewick School District Nursing Services