



DATE _____

STUDENT _____

MEDICATION _____

Dear Parent:

Thank you for arranging for your child to take medication at school this year. You can call the school to arrange to pick-up your child's medications. Any controlled substance medication such as ADHD or seizure rescue medications will need to be picked up. Unclaimed controlled substance medications or expired medication left in the building will be destroyed and unavailable on the first day of the new school year.

*Please be aware that if you leave unexpired medication in the building that is NOT a controlled substance over the summer a **new** physician's order for medication at school form will need to be filled out for the new school year. This is an annual requirement.*

If your child needs to take medication during school hours next school year, please have your health care provider complete appropriate medication at school forms. All medication and health forms for next year can be found on the Bethel Health Services web page or you may use the link below. Bring the completed and signed forms along with the unexpired medication in an original and labeled container that matches the Doctor's orders to school. Medications that do not fulfill requirements cannot be administered.

Enjoy your summer!

Bethel School District Health Services

bethelsd.org/resources/health-room-forms

Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

Student	Student Name: _____ Birth Date: _____ _____														
Released By	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student														
Released To	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student														
Purpose	For the purpose(s) of: <input type="checkbox"/> This information may be used or disclosed in connection with mental health treatment/services and healthcare operations. <input type="checkbox"/> Other purposes (specify each purpose): _____ _____														
Information to be Disclosed	Description or nature of information to be used and/or disclosed: (check all that apply) <input type="checkbox"/> Assessment/Intake Summary <input type="checkbox"/> Psychiatric Reports <input type="checkbox"/> Service/Treatment Plan <input type="checkbox"/> Progress Report <input type="checkbox"/> Safety/Crisis Plan <input type="checkbox"/> Other records(specify): _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;"> <b style="text-align: center;">Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released. </td> </tr> <tr> <td style="padding: 5px;"> <b style="text-align: center;">Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </td> <td style="padding: 5px;"> My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released. </td> </tr> </table>	<b style="text-align: center;">Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.	<b style="text-align: center;">Substance Use <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.										
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Notices	I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.														
Expiration	I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period: Date: _____														
Signatures	I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Signature of student</td> <td style="width: 20%; border-bottom: 1px solid black; text-align: center;">Date</td> <td style="width: 40%;"></td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Signature of legal/personal representative</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship to student</td> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%; background-color: #cccccc;">Update of Authorization</td> <td style="width: 45%; background-color: #cccccc;">Signature 1: _____</td> <td style="width: 15%; background-color: #cccccc;">Date: _____</td> <td style="width: 15%;"></td> </tr> <tr> <td style="background-color: #cccccc;"></td> <td style="background-color: #cccccc;">Signature 2: _____</td> <td style="background-color: #cccccc;">Date: _____</td> <td></td> </tr> </table>	Signature of student	Date		Signature of legal/personal representative	Relationship to student	Date	Update of Authorization	Signature 1: _____	Date: _____			Signature 2: _____	Date: _____	
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TUBO GÁSTRICO
SOLICITUD DE PROCEDIMIENTO EN LA ESCUELA
Distrito Escolar de Bethel #403

Nombre del estudiante: _____ Fecha de nacimiento: _____

Escuela: _____ Grado: _____

PARA SER COMPLETADO POR UN PROFESIONAL DE SALUD CON LICENCIA CON AUTORIDAD PRESCRIPTIVA

Tipo de tubo gástrico: _____ Talla: _____ Inflable: __ cc Fecha del reemplazo: _____

Motivo del tratamiento: _____ El tubo G se usa para: Alimentación Medicina Ambos

Tipo de fórmula/nutriente: _____

Cantidad: _____ Hora(s) de alimentación: _____ y PRN

¿Se debe de enjuagar con agua después de cada alimentación? Si No En caso afirmativo, cantidad _____ ml

¿Tiene el estudiante una bomba? Si No En caso afirmativo, ¿qué tipo? _____ Corre a (velocidad): _____ ml/hr.

Si la alimentación del estudiante requiere una bomba ¿puede el personal de la escuela desconectar la alimentación para terapias y cambiar pañales/ir al baño? Yes No

¿Se debe aspirar los residuos antes de dar la alimentación? Si No En caso afirmativo, el retorno residual que sea menor de _____ml

¿Ventilar antes de las comidas? Si No En caso afirmativo, ¿por cuánto tiempo? _____ minuto(s)

¿Cómo suele tolerar la alimentación? bien pobremente posición durante la alimentación: _____

Posición necesaria después de la alimentación: _____

¿Puede el estudiante comer/beber algo por vía oral? Si No En caso afirmativo, ¿qué tipo? _____

Si el tubo G se lleva a la escuela, El padre y/o tutor legal ha sido entrenando para reemplazar el tubo G

Marque todas las que aplican: El estudiante debe ver a su médico o cirujano para la re inserción del tubo G

Pare/suspenda la alimentación si: _____

Otras instrucciones: _____

Duración del servicio(s): Año escolar (mm/dd/aa) desde _____ hasta _____

Firma del proveedor de atención médica _____ Teléfono _____ Fax _____

Nombre del proveedor de atención médica en letra imprenta o sello _____ Fecha: _____

ESTA AUTORIZACIÓN ES VALIDA SOLO PARA EL AÑO ESCOLAR ACTUAL

PARA SER COMPLETADO POR EL PADRE O TUTOR LEGAL

Por favor, tenga en cuenta que el personal de la escuela no tiene capacitación universal para reemplazar los tubos G. Solicito que se le permita a la enfermera de la escuela o a la persona designada del personal a hablar sobre los problemas médicos de mi estudiante con los proveedores de atención médica y suministrar a mi estudiante (*nombre del estudiante*) _____ los tratamientos ordenados por (*Nombre del proveedor de atención médica*) _____ para el _____ año escolar. Con mi firma certifico que entiendo que la escuela no acepta ninguna responsabilidad por reacciones adversas cuando el tratamiento se administra de acuerdo con las instrucciones de atención medica del proveedor y **que recogeré al final del año escolar todos los suministros y equipos necesarios, de lo contrario serán destruidos.** Yo soy el padre/tutor legal del estudiante nombrado anteriormente.

- Notificare inmediatamente a la escuela cualquier cambio o cancelación.
- Entiendo que los servicios no comenzarán hasta que se complete la capacitación adecuada del personal calificado.
- Entiendo que debo proporcionar todos los suministros y equipos necesarios para realizar este servicio.

Firma del padre/tutor: _____ Fecha: _____

Número de teléfono del contacto: Casa _____ Celular _____ Trabajo _____ Otro _____

For questions or help completing these forms, please contact your School Nurse.

Bethel School District Health Services

Phone: 253-800-2000

Address: 516 176th Street East, Spanaway, WA 98387

Website: <https://www.bethelsd.org/resources/health-room-forms>

For required health forms, visit:

<https://www.bethelsd.org/resources/health-room-forms>