



Life-Threatening Conditions

Dear Parent and/or Guardian,

According to our records, your student has a life-threatening health condition. Washington State Law requires children with life-threatening conditions to have a medication or treatment order and health care plan on file prior to attending school. This law, called Substitute House Bill 2834, took effect on June 13, 2002. The medication or treatment order must address the life-threatening condition and it must be on file with the school prior to the child attending school.

Under the law, "life-threatening condition" means a health condition that will put the child in danger of death during the school day if a medication or treatment order is not in place. In addition, our school nurses will be responsible for putting a nursing care plan in place. The law provides that a child may not attend school in the absence of a medication or treatment order if the child has a life-threatening condition that might require medical services to be provided at school.

At the start of every school year you will need new medication order forms and plan of care filled out by your healthcare provider as well as unexpired medication in the original container, and an updated care plan that has been prepared by the school RN and signed by the parent/Guardian prior to the student's first day of school.

For your convenience forms have been included related to your student's health condition. You may also use the link included to access them on the Bethel School District website. Please ensure that your healthcare provider completes all forms and that their contact information is printed for any clarification needed. Note that there are permission portions of forms as well. Return this form to your child's school nurse as soon as possible.

Upon receipt of the information from your healthcare provider, the school nurse will contact you to develop an appropriate nursing plan. She will then need to train the staff. Your child may not be able to start school on the first day of school if the orders are not at school three business days prior to school starting.

Sincerely,

Bethel School District Health Services

bethelsd.org/resources/health-room-forms

Questionnaire for Parent of Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant medical history or conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____

2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO

If YES, please explain: _____

5. When was your child's last seizure? _____

6. Has there been any recent change in your child's seizure patterns? YES NO

If YES, please explain: _____

7. How does your child react after a seizure is over? _____

8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? YES NO
If YES, what process would you recommend for returning your child to classroom:

Basic Seizure First Aid

- Stay calm & track time
 - Keep child safe
 - Do not restrain
 - Do not put anything in mouth
 - Stay with child until fully conscious
 - Record seizure in log
- For tonic-clonic (grand mal) seizure:**
- Protect head
 - Keep airway open/watch breathing
 - Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? YES NO

If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration

* After 2nd or 3rd seizure, for cluster of seizure, etc.

** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? _____

16. Should any of these medications be administered in a special way? YES NO

If YES, please explain: _____

17. Should any particular reaction be watched for? YES NO

If YES, please explain: _____

18. What should be done when your child misses a dose? _____

19. Should the school have backup medication available to give your child for missed dose? YES NO

20. Do you wish to be called before backup medication is given for a missed dose? YES NO

21. Does your child have a Vagus Nerve Stimulator? YES NO

If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- General health _____
- Physical functioning _____
- Learning _____
- Behavior _____
- Mood/coping _____
- Physical education (gym/sports) _____
- Recess _____
- Field trips _____
- Bus transportation _____
- Other _____

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature _____ Date _____

Dates _____
Updated _____

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;"> 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;"> 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>	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.	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>