



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

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: 25%; 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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Pierce County Medical Society

HEALTH CARE PROVIDER EPINEPHRINE REQUEST AND TREATMENT PLAN FOR ANAPHYLAXIS

Table with 3 columns: School Year, School, Fax

Student Name: _____ may require treatment to prevent/treat anaphylaxis.

Student is allergic to _____

The symptoms of anaphylaxis may include breathing difficulty, facial/throat swelling or tingling, hives, rash, itching, stomach cramps, nausea/vomiting, dizziness, or swelling away from the site of a bee sting.

The treatment plan for preventing/treating anaphylaxis at school is as follows: (check all that apply)

If student is exposed to allergen and/or exhibits any symptom of anaphylaxis,

Give epinephrine IMMEDIATELY:

- Epinephrine auto-injector 0.3 mg, Epinephrine auto-injector 0.15mg, Repeat dose of epinephrine may be given if _____

Call 911 at the time epinephrine is given and notify parent/guardian.

This student also has asthma and may be at higher risk for developing anaphylaxis.

Student and parent/guardian have been instructed in use of epinephrine auto-injector. Student may carry and self-administer the epinephrine auto-injector ordered above.

Health Care Provider's Signature, Health Care Provider's Printed Name or Stamp, Telephone, Fax, Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

Parent's Permission

I request that the school nurse, principal, or designated staff member be permitted to administer to my child, (name of child) _____, or allow my child to carry and self-administer as indicated above, the medication prescribed by (name of health care provider) _____ for the _____ school year. The medication is to be furnished by me in the original container labeled by the pharmacy or health care provider with the name of the medicine, the amount to be taken, and when it should be taken. The health care provider's name is on the label. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the medication is administered, or my child self-administers, in accordance with the health care provider's directions. If notified by school personnel that medication remains at the end of the school year, I will collect the medication from the school or understand that it will be destroyed. I am the parent or the legal guardian of the child named.

Parent/Guardian Signature, Phone Contacts (Work, Home, Cell, Other), Date

Thank you for your assistance. Please return completed form to school nurse.

Student demonstrates skill level necessary to self-administer medication as ordered above. School Nurse Signature: Date: