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

GASTRIC-TUBE
PROCEDURE REQUEST AT SCHOOL
Bethel School District #403

Student Name: ______________________ Birthdate: ______________

School: ______________________ Grade: ______________

TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Type of Gastrostomy Tube: ______________ Size: ________ Inflate: _ cc Date of Replacement: ____________

Reason for Treatment: ______________________ G-Tube used for: ☐Feeding ☐Medication ☐Both

Type of Formula/Nutrient: ______________________

Amount: ______________________ Time(s) of Feeding(s): ______________ and ☐ PRN

Flush with water after each feeding? ☐Yes ☐No If YES, amount ______________ ml

Is student on a pump? ☐Yes ☐No If YES, what type? ______________ Run at: ________ ☐ml/hr

If student feeding requires pump, school staff may disconnect feeding for therapies and diapering/toileting? ☐Yes ☐No

Aspirate residual before feeding? ☐Yes ☐No If YES, return residual if less than ______________ ml

Vent before feedings? ☐Yes ☐No If YES, for how long? ____________ Minute(s)

How is feeding usually tolerated? ☐Good ☐Poor Position during feeding: ______________

Position needed after feeding: ______________________

Can student eat/drink anything by mouth? ☐Yes ☐No If YES, what type? ______________

If G-Tube is displaced at school, *check all applicable boxes*:
☐ Parent and/or legal guardian has been training to replace G-tube
☐ Child must see their doctor or surgeon for reinsertion of the G-tube

Hold feedings if: ______________________

Other Instructions: ______________________

Duration of order(s): ☐School Year ☐ (mm/dd/yr) ______________ to ______________

____

Health Care Provider's Signature Phone Fax

____

Health Care Provider's Printed Name or Stamp Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY

TO BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN

Please be aware that the school staff do not have universal training to replace G-tubes. I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child *(name of child)* ______________________ the treatment prescribed by *(name of health care provider)* ______________________ for the ______________ school year. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed.
- I understand that I must provide all necessary supplies and equipment to perform this service.

Parent/Guardian Signature: ______________________ Date: ______________

Phone Contacts: Home ____________ Cell ____________ Work ____________ Other ____________

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:

☐ This information may be used or disclosed in connection with mental health treatment/services and healthcare operations.

☐ Other purposes (specify each purpose): ______________________________

Information to be Disclosed

Description or nature of information to be used and/or disclosed: (check all that apply)

☐ Assessment/Intake Summary ☐ Psychiatric Reports

☐ Service/Treatment Plan ☐ Progress Report

☐ Safety/Crisis Plan ☐ Other records(specify): ____________________

Mental Health ☐Yes ☐No ☐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 ☐Yes ☐No ☐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.

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.

______________________________ ____________________
Signature of student Date

______________________________ ____________________ ____________________
Signature of legal/personal representative Relationship to student Date

Update of Authorization Signature 1: ____________________ Date: ____________________

Signature 2: ____________________ Date: ____________________