



Individual Health Plan

Seizure Disorder- Medication at School

Completed by Health Care Provider

Student
Photo

Name: _____ **Birth Date:** _____

Diagnosis/Seizure Type: _____ Last know seizure: _____

Brief description of condition: _____

Date of last EEG: _____ Results: _____

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

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

Behavior **after** Seizure: _____

How would this current condition adversely affect student's educational performance/attendance? _____

Medication and dosage taken at home: _____

Possible side effects of medication that school personnel need to be aware of: _____

Emergency Medication to be available at School No Yes, if yes, which medication?
 Intranasal Midazolam (Med order required) Rectal Diazepam (Med order required)
 If nurse is not available to administer, 911 should be called after ___minutes

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 5 minutes The person has a series of seizures The student requests to be transported Rectal diazepam or nasal midazolam is administered by district nursing staff.

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:** _____

Date Reviewed with Parent (To be updated at least every 3 years)

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature



AUTHORIZATION FOR MUTUAL RELEASE OF RECORDS

Kennewick School District Nursing Services

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 the records to be disclosed: Diagnoses, medication and any medical recommendations that are applicable for the student at school.

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

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).

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

I understand that 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