



# Medical Condition Documentation

Completed by Health Care Provider

Student Photo

Name:

Birth Date:

Diagnosis: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Brief description of condition: \_\_\_\_\_

How would this current condition adversely affect student's educational performance? \_\_\_\_\_

Home medication and dosage: \_\_\_\_\_

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

If needed - Action Plan: If sending symptomatic student anywhere, send with an escort

<b>Call 911 if:</b>	<b>Then do:</b>

**Further recommendations from HCP: (classroom, school bus, field trips, disaster etc.)**

If medication for condition is required at school, complete the following.

Name of Medication(s)	Dose	Time of day to be given

Side effects of drug (if any) to be expected: \_\_\_\_\_

Length of time this authorization is valid (no longer than current school year): \_\_\_\_\_

***I request and authorize this student to carry their medication/self-administer. They have demonstrated proper use in my office. Yes No School Nurse approval \_\_\_\_\_***

Health Care Provider Signature:	Date:
Health Care Provider name (print or type)	
Phone:	Fax:
School Nurse Signature:	Date:

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

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

**Parent Permission (to be completed by parent or guardian)**

- By law my signature indicates that I understand the district shall incur no liability as a result of any injury arising from the administration of medication by the KSD staff or as self-administered by the student.
- Parents or guardians shall hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication.

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATION AT SCHOOL RULES**

- Prescription medications must be in the original labeled container from the pharmacy.
- Over-the-counter medication must be in the original container.
- Any changes to this medication will require a new medication form completed by both parent and health care provider.
- Under normal circumstances prescribed oral, nasal spray, topical, eye drop or ear drop medication and over-the-counter oral, nasal spray, topical, eye drop or ear drop medication should be dispensed before and/or after school hours under supervision of the parent / guardian.
- Medications will only be dispensed at school when failure to receive the medication may result in the student being unable to attend school or to be well enough to participate in learning activities.
- If a student must receive prescribed or over-the-counter medication during school hours, the parent must submit a Medication at School form completed and signed by both the parent and a licensed health care provider.
- Only the amount of medication needed during school hours for the course of the illness/condition is to be sent to school, not to exceed a one month's supply.
- Medications that must be given in half-pill doses must be cut by the pharmacy or the parent. The school will not cut pills.
- Parent or designated adult to bring medication to school (students should not transport medication to school).
- When the duration of a medication is complete or out of date, or at the end of the school year, the parent must pick up any unused portions of the medication. Unclaimed medications will be discarded.
- Bus drivers will not transport or administer medication.
- In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

**Authorization for Mutual Exchange of Confidential Information**

***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***

<b>From:</b>		<b>To:</b>	
<b>Agency/Person:</b> _____	<b>Agency/Person:</b> <u>KSD Nurse</u>		
<b>Street Address:</b> _____	<b>Street Address:</b> _____		
<b>City, State, Zip:</b> _____	<b>City, State, Zip:</b> <u>Kennewick, WA,</u>		
<b>Tel:</b> _____	<b>Fax:</b> _____	<b>Tel:</b> <u>509-222-</u>	<b>Fax:</b> <u>509-222-</u>

Describe records to be disclosed: **Diagnoses, medication, medical recommendations applicable for student at school.**

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

*This authorization is valid from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_.*

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).

I understand 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: \_\_\_\_\_