KENNEWICK
SCHOOL DISTRICT

Rectal Diastat MEDICATION AT SCHOOL

Whenever possible, the parent and Health Care Provider will design a schedule for giving medication outside of school hours. Medication is ordered to be given to a student at school only when necessary. Medication, unless otherwise directed, will be kept in a designated secure area and administered by the school nurse or trained school personnel.

Health Care Provider's Orders (*to be completed by Health Care Provider*)

Student:		Birth date:
Diagnosis for which medication is given:		
Name of Medication(s)	Dose	Time of day to be given

**** IF rectal Diastat is administered at school, an ambulance will be called after ONE dose and the student will be transported to the nearest hospital.**

Side effects of drug (if any) to be expected:
All rectal meds must be administered by a RN or LPN in school**. *If no nurse is on the premises, EMS to treat the student's seizure.***
Length of time this authorization is valid:

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

Prescription medications must be labeled by the pharmacy with the name of the patient, health care provider, medication, dosage, and the time of day to be given. **Any change in medication, dose or time must be handled as a new medication, as well as any change in provider,** and a new form completed by both parent and health care provider. In case of necessity, the school district may discontinue administration of the medication with proper advance notice.

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

I request that my child be allowed to take medication as described above.

The medication will be furnished by me in the original container, and **BROUGHT TO SCHOOL BY AN ADULT.**

My signature indicates my understanding that the school accepts no liability for untoward reaction when the medication is administered in accordance with the physician's directions.

I am the parent or the legal guardian of the child named.

Signature of parent or guardian:_____ Date: _____

Parent phone (work)_____ (home)_____

This authorization is good for the current school year.

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 heath 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

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 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: