FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT

SEIZURE/EPILEPSY PACKET

Dear Parent/Guardian,

You indicated that your child has epilepsy or has been known to experience seizures that may require nursing intervention/monitoring and/or medication. In order to ensure the safety of your child while attending school, we ask that you and your child's physician please complete all applicable forms in the following packet. In addition to completing the paperwork, we would advise you to obtain additional doses of any required medication to have at school in the event of a prolonged seizure.

Please bring your child's labeled medication (if prescribed) to the health office by the first day of school, along with the completed packet. The school nurse will want to meet with you to review the types of seizures and symptoms your child experiences. Please call the school nurse at your earliest convenience to discuss your child's health considerations for this school year.

Thank you

PAQUETE DE INFORMACIÒN PARA CONVULSIONES / EPILEPSIA

Estimado Padre / Tutor,

Usted indicó que su hijo tiene epilepsia o se sabe que sufre convulsiones que pueden requerir intervención / monitoreo de enfermería y / o medicamentos. Para garantizar la seguridad de su hijo mientras asiste a la escuela, le pedimos que usted y el médico de su hijo completen todos los formularios correspondientes en el siguiente paquete. Además de completar el papeleo, le aconsejamos que obtenga dosis adicionales de cualquier medicamento requerido para tener en la escuela en caso de una convulsión prolongada.

Lleve el medicamento etiquetado de su hijo (si está recetado) a la oficina de salud de su escuela antes del primer día de clases, junto con el paquete completo. La enfermera de la escuela querrá reunirse con usted para revisar los tipos de convulsiones y síntomas que experimenta su hijo. Llame a la enfermera de la escuela tan pronto como sea posible para discutir las consideraciones de salud de su hijo para este año escolar.

Gracias

FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT

Fallbrook Union Elementary School District
Health Services Seizure Action Plan

Student Name:	Date of Birth:	Effective Date:	Student ID#:
Parent/Guardian:	Phone Number:	Parent/Guardian:	Phone Number:
Treating Physician:		Phone Number:	Fax:

Seizure Type	Length	Frequency/Last Seizure	Description

Triggers/Warning Signs	First Aid/Care and Comfort	Emergency Response

TREATMENT PROTOCOL DURING SCHOOL HOURS		
Medication	**Dosage & Frequency**	**Side effects/Instructions**
Does the student have a Vagus Nerve Stimulator: NO YES -		

Physician signature: _____ Date: _____

Parent signature: _____ Date: _____

District Nurse signature: _____ Date: _____

FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT

PARENT/GUARDIAN STATEMENT

Board Policy 5141.21 Administering Medication and Monitoring Health Conditions

Any pupil who requires medication or prescribed health services, may be assisted by a school nurse or other designated school district personnel if the district receives this PARENT/GUARDIAN STATEMENT and a HEALTH CARE PROVIDER STATEMENT. This authorization is valid only for the current school year.

The HEALTH CARE PROVIDER STATEMENT must be completed by an individual licensed by the State of California to prescribe or order medication including, but not limited to, a physician or physician assistant. The statement should include the medication name, route of administration, amount (dose), time and reason by which such medication is to be taken, as well as side effects.

I, the parent/guardian, agree to provide a new PARENT/GUARDIAN STATEMENT and HEALTH CARE PROVIDER STATEMENT if there is a change in the prescribed medication or health service.

I, the parent/guardian, acknowledge that medication and health service should be administered at home whenever possible. Medication and health services should only be administered at school when it is necessary for continued attendance or an emergency. Medication/health services that are administered once, twice or three times daily should be administered at home before and after school when possible.

I, the parent/guardian, agree to provide medication in original containers which are clearly marked with my child's name, name of the medication and expiration date. Medication bottles at school should not be "refilled" from another bottle. Medication must be brought to school by a parent/guardian unless my child has a self-carry agreement between the physician, parent, student and school. If my child has a self-carry agreement, I consent to allow my child to self-administer/carry medication and supplies. I release the district and school personnel from civil liability if my child suffers an adverse reaction as a result of providing self-care.

I, the parent/guardian, acknowledge that my child may receive medication or assistance from a school nurse or other district designee according to Education Code Section 49423. I recognize that I am responsible for providing all necessary supplies and equipment. This is a service or accommodation which the school is not legally required to perform. I agree to waive and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication, or health service, in accordance with this request.

I, the parent/guardian, grant permission for an authorized district representative to communicate directly with my child's authorized health care provider and pharmacist, as may be necessary, regarding the health care provider's written statement or any other questions that may arise with regard to the prescribed medication(s) or health service(s).

I, the parent/guardian, understand that I may terminate this authorization for medication administration or other prescribed health services for my child at any time. I request that a school nurse or other district designee administer the medication/services as directed by the physician, for my child:

_____

Student's Name

_____ _____

Parent / Guardian Signature Date

_____ _____

Home / Cell Phone Number Work Phone Number

FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT

DECLARACIÓN DEL PADRE/TUTOR

Póliza de la Directiva 5141.21 Administración de Medicamentos y Supervisión de Condiciones de Salud

Cualquier alumno(a) que requiera medicamento o servicios de salud prescritos puede ser asistido por la enfermera de la escuela o cualquier otro miembro del personal del distrito asignado si el distrito recibe esta DECLARACIÓN DEL PADRE o TUTOR y una DECLARACIÓN DEL PROVEEDOR DEL CUIDADO DE SALUD. Esta autorización es únicamente válida para el año escolar en curso.

Un individuo con licencia del Estado de California para recetar y ordenar medicamentos incluyendo pero no limitado a un médico o asistente médico debe llenar la DECLARACIÓN DEL PROVEEDOR DEL CUIDADO DE SALUD. La declaración debe incluir el nombre del medicamento, vía de administración del mismo, cantidad (dosis), la hora y la razón por la cual tal medicamento debe tomarse, así como los efectos secundarios.

Yo, el padre/tutor, acepto proporcionar, una nueva DECLARACIÓN DEL PADRE/TUTOR y DECLARACIÓN DEL PROVEEDOR DEL CUIDADO DE SALUD si hay un cambio en el medicamento recetado o el servicio de salud.

Yo, el padre/tutor, estoy consciente que el medicamento y servicio de salud debe administrarse en el hogar cuando sea posible. Los medicamentos y servicios de salud únicamente deben administrarse en la escuela cuando sea necesario para la asistencia continua o una emergencia. Los medicamentos y servicios de salud que se tienen que administrar una, dos o tres veces al día deben administrarse en casa antes y después de clases cuando sea posible.

Yo, el padre/tutor acepto proporcionar el medicamento en su frasco original el cual está claramente etiquetado con el nombre de mi hijo(a), nombre del medicamento y día de expiración. Los frascos de medicamento que se encuentran en la escuela no se deben rellenar con medicamento de otros frascos. El medicamento debe ser llevado a la escuela por el padre/tutor a menos que mi hijo(a) tenga un acuerdo entre el médico, padre, estudiante y escuela de llevar el medicamento por sí mismo(a). Si mi hijo(a) tiene un acuerdo para llevar su propio medicamento, le autorizo a llevar su medicamento y artículos, y que se lo administre él/ella mismo(a). Yo libero al distrito y el personal escolar de cualquier responsabilidad civil si mi hijo(a) sufre una reacción adversa como resultado de proporcionarse cuidado de salud a sí mismo(a).

Yo, el padre/tutor estoy consciente de que mi hijo(a) puede recibir medicamento o asistencia de la enfermera de la escuela u otra persona asignada de acuerdo con el Código de Educación Sección 49423. Yo acepto que soy responsable de proporcionar todos los artículos necesarios y equipo. Este es un servicio o adaptación que la escuela no está legalmente obligada a llevar a cabo. Acepto renunciar y eximir al distrito, sus funcionarios, empleados o agentes de toda responsabilidad demanda o reclamo de cualquier naturaleza o clase que pueda surgir como resultado de la administración del medicamento o servicio de salud, de acuerdo con esta petición.

Yo, el padre/tutor otorgo mi permiso para que un representante autorizado del distrito se comunique directamente con el proveedor de cuidado de salud y el farmacéutico autorizados de acuerdo como sea necesario con respecto a la declaración por escrito del proveedor de cuidado de salud o cualquier otra cuestión que surja con respecto al/los medicamento(s) prescrito(s) o servicios de salud.
Yo, el padre/tutor, entiendo que puedo rescindir esta autorización para la administración de medicamentos u otros servicios de salud recetados para mi hijo(a) en cualquier momento. Solicito que la enfermera de la escuela u otra persona designada por el distrito administre el/los medicamento(s)/servicio(s) como lo indica el médico para mi hijo(a).

_____
Nombre del Estudiante

_____ _____
Firma del Padre o Tutor Legal Fecha

_____ _____
Número de Teléfono del Hogar o Celular Número de Teléfono del Trabajo

FALLBROOK UNION
ELEMENTARY SCHOOL DISTRICT

Authorization for use or Disclosure of Health Information to School Districts

Completion of this document authorized the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Use and Disclosure Information:

Patient/Student Name: _____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and / or health care providers):

1) _____ 2) _____
to provide health information from the above-named child's medical record to and from:

_____ _____
School District to Which Disclosure is made Address / City and State / Zip Code

_____ _____
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____
Requested health information shall be limited to the following: All health information or
Disease specific information as described:

_____

Duration: This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature, if no dated entered.

Restrictions: Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

Your Rights: I understand that I have the following rights with respect to this Authorization: ***I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies / persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.***

Re-Disclosure: I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of the Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.
Approval:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient / Student Area Code and Telephone Number