CAMPBELL COUNTY SCHOOLS

HEALTH SERVICES

Mrs. Diana Taylor, R.N.
District Health Coord.

909 Camel Crossing
Alexandria, KY 41001

Telephone: 635-4161

Dear Parent or Guardian:

In preparation for the upcoming school year, it is important that we have accurate information/authorization to meet the special needs of your child in the school setting.

Please have your child's physician complete the information on the enclosed forms prior to the beginning of school. This information will be used to develop an Individual Health Care Plan for your child in the school setting. Medications/procedures will not be administered until all forms are properly completed and the parent/guardian provides medications and all supplies required.

If your child has diabetes, Children's Hospital now provides a school packet containing all information required for school attendance for those students managed through their clinic. Please contact them now and ask that the packet be completed.

After July 25, please contact the principal of the school your child will attend to set a time to meet with appropriate staff. If you have further questions, please contact me at: 635-4161, ext. 2252.

Thank you in advance for your cooperation. With your help we can insure a smooth transition for your child into the new school year.

Sincerely,

Diana Taylor, R.N.
District Health Coordinator
Campbell County Schools

CAMPBELL COUNTY SCHOOLS HEALTH SERVICES

SEIZURES: Individualized Health Care Plan (IHP)

SCHOOL YEAR _____

Student Name: _____ **DOB:** _____ **Grade:** _____
School: _____ **Bus# A.M.** _____ **Bus# P.M.** _____

Emergency Contact Information:

Parent/Guardian: _____ Work Phone: _____ Home: _____
Parent/Guardian: _____ Work Phone: _____ Home: _____
Emergency Contact: _____ Phone: _____

****Parent/guardian is responsible for all medication & supplies designated in this health care plan***

Type(s) of seizure(s) student has: _____
How does student present during seizures? _____
_____
Length of seizures: _____
Frequency of seizures: _____
Date of last seizure: _____
Events or triggers which may precipitate a seizure: _____
_____
Behavior changes/warning signs of impending seizure: _____
_____
Special adaptive/safety equipment needed: _____

Rescue meds/devices:

____ **VNS Parameters:** _____
____ **Diastat Parameters:** _____
____ **Nasal Versed Parameters:** _____
____ **None**

Contact the parent in the following situations: _____
_____

Campbell County School District First Aid For Seizures

1. **Stay Calm. Begin timing seizure as soon as noted. Observe the activity**
2. **Ease student to floor if needed. Never move a student having a seizure unless a threat to their safety is noted. Clear the area of furniture/objects which might pose a risk to the student. Instruct classmates to move to another area.**
3. **Position student on side and cushion head. NEVER FORCE ANYTHING INTO THE PERSON'S MOUTH. There is no danger of swallowing the tongue.**
4. **Notify office/nurse/trained personnel/parents**
5. **Administer emergency treatment as ordered per physician if required.**

****EMS (911) will be notified if Diastat/Nasal Versed given in response to prolonged seizure activity per Campbell County Protocol****

Trained School Personnel:

1._____ **Rm:** _____

2. _____ **Rm:** _____

3. _____ **Rm:** _____

Cincinnati Children's Hospital Medical Center

Authorization for Use and/or Disclosure Of Protected Health Information to Schools

MEDICAL RECORD #: _____

PATIENT INFORMATION (Please Print):

Last Name	First Name	Middle Initial	Maiden Name (if applicable)	Gender

Address	City	State	Zip Code	Phone Number

Date of Birth	Social Security Number	Email Address (optional)

Please check/specify the following type of information, including dates of treatment, that you want to be disclosed pursuant to this Authorization. Failure to specify will render this Authorization invalid.

Dates of Treatment/Particular Illness/Admission Requested: _____

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Educational Evaluations
- ☐ Speech and Language Evaluations
- ☐ Occupational Therapy/Physical Therapy Evaluations
- ☐ Hospital School Attendance
- ☐ School Recommendations
- ☐ Academic/Educational Information
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____
- ☐ ALL INPATIENT MEDICAL RECORDS (See Note)
- ☐ ALL OUTPATIENT MEDICAL RECORDS (See Note)

Purpose for Disclosure

☒ School

The purpose of the use and/or disclosure of this information is to best provide for the student's educational, physical and emotional adjustment between the hospital setting and the school setting.

Disclose Records To:	
Name	
School	
Title	
Street Address	
City, State, Zip	
Telephone Number	

Records may be:
- ☐ Mailed
- ☐ Reviewed only
- ☐ Faxed
- ☐ Picked up by Whom: _____
- ☐ In-Person Meeting
- ☐ Shared by Telephone

This Authorization will expire 60 days after the date below, or sooner by my choice, in which case, Authorization will expire on _____, or _____ (event) occurs. This Authorization may be revoked at any time to the extent that use and/or disclosure has not already occurred prior to your request for revocation. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Health Information Management department, 636-8233. Please refer to Cincinnati Children's Hospital Medical Center's (CCHMC) Notice of Privacy Practices.

CCHMC will not condition treatment, payment, enrollment or eligibility for benefits on the execution of this Authorization. The information used or disclosed as a result of this Authorization may be subject to redisclosure by the person or entity receiving such information, and thus no longer protected by the federal privacy regulations. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

I, the undersigned, hereby authorize Cincinnati Children's Hospital Medical Center to use and/or disclose information from my (or give relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

Signature: _____ **Date:** _____ ☐ **Patient** ☐ **Parent** ☐ **Legal Guardian**

The above statements must be signed and dated to be valid. If the patient is an emancipated minor or 18 years of age, he/she is required to sign the Authorization. If CCHMC requests this Authorization for its own use or disclosure, a copy of this Authorization must be provided to the individual completing this form.

Request Has Been Fulfilled: ☐ **Yes, Initials** _____ **Date** _____

CAMPBELL COUNTY SCHOOLS
CONSENT FORM FOR ADMINISTERING MEDICATION AT SCHOOL

Student's Name _____ **Grade** _____

Name of Medication _____

Dosage _____

Route of Administration _____

Time(s) To Be Given _____

Diagnosis Or Reason For The Medication To Be Given _____

Possible Side Effects: _____

Student's Allergies: _____

Name of Prescribing Doctor _____

_____ _____

Signature of Prescribing Doctor **Date**

Phone Number of Prescribing Doctor _____

****

I request my child be permitted to take medication as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____

Signature of Parent/Guardian **Date**

_____

Name of School Submitted To

Revised 7/09

CAMPBELL COUNTY SCHOOLS

Student Medical Care

Administration of Medication at School

Since it is recognized that some students are able to attend school because of the effectiveness of medications in the treatment of chronic disabilities and illnesses, this procedure has been adopted to help insure safe administration of medications in school.

A. No medication may be administered to students by an employee of the Campbell County Board of Education unless there is written permission from the parent or guardian and the prescribing physician, if indicated.

B. Only doses of medication that cannot be administered at home will be given at school.

C. Any student who is required to take medication during regular school hours shall comply with the following:

1. No medication will be supplied by the school.
2. Medications shall be brought to school in the original container that is properly labeled with the following information:
    a. Name of Student
    b. Name of Medication
    c. Dosage of Medication
    d. Time Medication is to be Administered
3. Nonprescription medication will only be given with written advice of a physician.
4. Medications that contain narcotics or sedation for pain will NOT be administered at school to help insure student safety.
5. Medications adequate for one school week only should be sent to school.
6. Medications should be sent in the form that it is given. School staff will not divide tablets, etc.
7. All medication should be kept in the school office in a specified safe place. Students are not permitted to have medication in their possession.
8. Self-managed/self-carry administration of emergency medication (insulin, asthma inhalers, epinephrine) will be permitted with written authorization of parent and physician on form provided by the school.
9. It is the student's responsibility to comply with the doctor's order concerning administration of medications. Upon receipt of the signed consent form, school personnel will endeavor to assist students with medication.
10. Every dose of medication administered by school personnel shall be recorded on a prescribed form.

***School personnel responsible for administration of medications will refuse to administer medications if the above guidelines are not followed. In such situations the parent/guardian will be notified.

AGREEMENT FOR THE ADMINISTRATION OF EMERGENCY CARE

The undersigned parent/guardian of _____
a pupil in the Campbell County Public Schools, has advised the Board of Education of Campbell County that his/her child named above suffers from a medical condition which may be life threatening unless immediate emergency care is provided in a crisis which may arise from the child's health problem.

Accordingly, the Board of Education of Campbell County has adopted a procedure wherein a member of the staff of the school the child is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the child's physician in the case of a life-threatening emergency wherein immediate intervention is required by the volunteer.

The undersigned parent/guardian does hereby consent to the intervention of the volunteer staff member in accordance with the instructions contained in the attached letter from the child's physician. Additionally, the undersigned agrees to hold that volunteer harmless for any injuries resulting from the emergency care unless the injury was caused by the volunteer's negligence.

Dated at Alexandria, Kentucky, this the _____ day of _____. _____
(Day) (Month) (Year)

X _____
(Parent/Guardian Signature)