School Year:_____ - _____

RICHLAND School District

Place studen's picture re

MEDICAL FORM: SEIZURE/EPILEPSY
(EMERGENCY CARE PLAN/MEDICAL 504)

Student's Name: _____ Birth Date: _____ Grade/Teacher: _____

This care plan is to be completed by the child's Health Care Provider:

What type of seizures does the student have?

- ☐ Simple Partial
- ☐ Absence (Petit Mal)
- ☐ Complex (Psychomotor/Temporal lobe)
- ☐ Infantile Spasm
- ☐ Atonic Seizures (Drop Attacks)
- ☐ Generalized Tonic-Clonic (Grand Mal)
- ☐ Myoclonic
- ☐ Other:

Do you consider this student's seizure condition to be life threatening? ☐ **NO** ☐ **YES**

Treat this student's seizure as an EMERGENCY if:	For a seizure EMERGENCY, do this:
• A convulsive (tonic-clonic) seizure lasts longer than _____ **minutes** ← *indicate time* • The student has a cluster of seizures • The student is injured • The student has breathing difficulties • The student has a seizure in water • Other: _____	• **CALL 911, transport to nearest Emergency Department** *If guardian does not arrive before transport, staff member will accompany student to hospital and sty until guardian arrives* • Continue to provide basic seizure first aid • Notify parent, or emergency contact if unable to reach parent *(see phone numbers on reverse side)* • If prescribed below, a trained staff member will administer emergency medication (see below) • Notify doctor: _____ • Other: _____

Accommodations:

- This student is to wear a helmet at school and during transport: ☐ NO ☐ YES
- This student has a Vagal Nerve Stimulator (VNS): ☐ NO ☐ YES (if yes, please attach instructions)
- Other: _____

Is emergency medication prescribed for use during school hours? ☐ NO ☐ YES (see box below)

This box is for school EMERGENCY SEIZURE MEDICATION only. Use a Medication Authorization form for all other drugs.

MEDICATION	DOSAGE	ROUTE	TIME / FREQUENCY	SIDE EFFECTS
Emergency seizure medication:				
72 hr supply of maintenance medication:				

Medication authorization: I request and authorize that the above named student be administered the above identified medication in accordance with the instructions indicated above. This authorization is valid until the last day of school *or*: _____/_____/20____ (not to exceed the current school year). A health condition makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

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

Note: Medical forms (including care plans and medication authorization) need to be renewed each year prior to the start of school, and again at any time the physician or parent requests a change to the order.

Order reviewed by school RN (signature): _____ **Date:**_____

Please note - Unlicensed school staff are not permitted to administer a suppository.

School Year:_____ - _____

This section to be completed by the child's Parent/Guardian:

Student's Name: _____ Birth Date: _____

Parent/Guardian:_____ Home: _____ Cell:_____ Other:_____

Parent/Guardian:_____ Home: _____ Cell:_____ Other: _____

Emergency Contacts (To be called if unable to reach parent) **Please update your school office when contact information changes*

Name:_____ Relationship:_____ (PH):_____ (PH): _____

Name: _____ Relationship:_____ (PH): _____ (PH):_____

Primary provider:_____ Phone: _____ Fax: _____

Specialist:_____ Phone: _____ Fax: _____

Known Drug Allergies:_____ Does your child take the bus? ☐ Yes ☐ No

Medication taken at home	Dose & Time of Day Given	Common Side Effects & Special Instructions

- **Important medical history to know: (include hospital stays, surgeries, etc)** _____

_____

_____

- **Special Considerations and Safety Concerns (for activities, sports, trips, etc.)** _____

_____

_____

Does your child experience an aura prior to seizure? If yes, describe: _____

What my child's seizures look like:	During a seizure, my child needs:	After a seizure, my child needs:
	Basic Seizure First Aid: Stay calm & track time Keep my child safe Do not restrain my child Do not put anything in mouth Stay with my child until fully awake Record seizure in log **For tonic-clonic (grand mal) seizure:** Protect head Keep airway open/watch breathing Turn my child on side	

PARENT/GUARDIAN PERMISSION AND CONSENT FOR 504 PLAN:

• I understand that a 504 meeting with the school nurse must occur. I request to have this meeting:
(please intitial one) _____ via telephone OR _____ in person, at my child's school [Office Use Only: Date of 504 Mtg ___/___/___]

• I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I consent for my child to be evaluated for a health care plan/medical 504 plan. I have received a copy of the Notice of Parent/Student Rights under Section 504 (Form 504-1). I agree with this health care plan/medical 504, consent for the placement outlined, and request designated school personnel · to follow this plan as it is written. I understand that if I disagree with this plan, I have the right to request a hearing by filing a written request using the 504-7 form. I understand that this health care plan/medical 504, including the medical treatment/medication orders provided, must be renewed and reviewed annually. I understand that my child will be reevaluated every three years to determine if my child continues to qualify for a school health care plan/medical 504.

• I give health services staff permission to communicate with the LHCP's office about any medical treatment/medication orders that I provide to the school, in accordance with HIPPA/FERPA regulations. I understand that the school may share this care plan with emergency responders if student requires emergency services.

• If medication is prescribed within this plan, the medication is to be furnished by me in the original container, and BROUGHT TO SCHOOL BY AN ADULT. Prescription medication 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. I understand medication may be administered by non-licensed trained designated staff members in accordance with state regulations and district policy. I understand that at the end of the school year, an adult must pick up any mediation, otherwise it will be discarded.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

RICHLAND SCHOOL DISTRICT NOTICE OF PARENT/STUDENT RIGHTS UNDER SECTION 504
(Form 504-1)

The Rehabilitation Act of 1973 ("Act"), commonly referred to as "Section 504," is a non- discrimination statute enacted by the United States Congress. The purpose of the Act is to prohibit discrimination and to assure that disabled students have educational opportunities and benefits equal to those provided to non-disabled students.

This is a notice of your rights under Section 504. This document is not intended to address the rights afforded under the Individuals with Disabilities Education Act ("IDEA") that applies to students eligible for special education services. The Office of the Superintendent of Public Instruction's ("OSPI") Notice of Special Education Procedural Safeguards for Students and Their Families is available through the District's Special Education Department and sets out the rights assured by the IDEA. It is the purpose of this notice to set out the rights assured by Section 504 to those disabled students who have a physical or mental impairment that substantially limits one or more major life activity who do not qualify under the IDEA.

Federal laws and regulations provide parent(s)/guardian(s) and students with the following rights:

1. You have the right to be informed by the District of your rights under Section 504 (the purpose of this notice is to advise you of those rights).

2. You have the right to have your child participate in and benefit from the District's education program without discrimination based on disability.

3. You have the right to receive notice before the District takes any action regarding the identification, evaluation, and/or placement of your child.

4. Your child has a right to an evaluation prior to an initial Section 504 placement and any subsequent significant change in placement. You have the right to refuse consent for the initial evaluation and initial placement of your child.

5. You have the right to have your child receive a free appropriate public education ("FAPE"). This includes your child's right to be educated with non-disabled students to the maximum extent appropriate. It also includes the right to have the District provide related aids and/or services to allow your child an equal opportunity to participate in school activities, educational, and/or related aids and services provided to your child without cost except for those fees imposed on the parent(s)/guardian(s) of non-disabled children.

6. Your child has a right to facilities, services, and/or activities that are comparable to those provided for non-disabled students.

7. You have the right to have evaluation, educational, and/or placement decisions for your child based upon information from a variety of sources, by a group of persons who know your child, your child's evaluation data, and/or placement options.

8. You have the right to have your child be provided an equal opportunity to participate in non-academic and extracurricular activities offered by the District.

9. You have the right to examine your child's education records and obtain a copy of such records. You also have the right to receive a response to reasonable requests for explanations and interpretations of your child's education records.

10. You have the right to request the District to amend your child's education records if you believe that they are inaccurate, misleading, and/or otherwise in violation of the privacy rights of your child. If the District refuses this request, you have the right to challenge such refusal under the Family Educational Rights and Privacy Act ("FERPA").

11. You have the right to request mediation or an impartial hearing with respect to the District's actions regarding your child's identification, evaluation, and/or educational placement with opportunity for parental participation in the hearing and representation by an attorney.

12. If you wish to challenge the actions of the District in regard to your child's identification, evaluation, and/or education placement, you should file a written request for a hearing with Mike Hansen, Student Section 504 Program Coordinator, 615 Snow Ave, Richland, Washington 99352; email to: mike.hansen@rsd.edu using the Request for a Hearing (Form 504-2). A hearing will be scheduled before an impartial hearing officer and you will be notified in writing of the date, time, and place of the hearing.

13. If you disagree with the decision of the impartial hearing officer, you have a right to review that decision by a court of competent jurisdiction. If you prevail in a civil rights action against the District, you have the right to seek the payment of reasonable attorney's fees through the court.

14. You have the right to file a local grievance or complaint with the U.S. Department of Education's Office for Civil Rights or file a complaint in federal court. The address of the Regional Office that covers Richland:

U.S. Department of Education Office of Civil Rights
915 Second Avenue, Room 3310
Seattle, Washington 98174-1099
Phone: (206) 607-1600
Website: www.ed.gov/OCR
Email Address: OCR.seattle@ed.gov