

DeWitt-Lavaca Special Education Cooperative
STUDENT HEALTH INFORMATION



I, the undersigned, do hereby authorize for the School Nurse to share the following information with classroom teachers or others who will be caring for my child while he/she is in school attendance.

.....
Last name, First name Middle name

.....
Local family doctor:

.....
Phone number:

.....
Dentist:

.....
Phone number:

Medications taken at home:

Medications taken at school:

Indicate yes (Y) or no (N) for the following conditions:

	Y	N		
Heart condition?	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<u>Circle:</u> Mild / Moderate / Severe	Inhaler at school? <input type="checkbox"/> <input type="checkbox"/>
Diabetic?	<input type="checkbox"/>	<input type="checkbox"/>		
ADHD?	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Type:	Date of last seizure:
Allergies to medicine?	<input type="checkbox"/>	<input type="checkbox"/>	List:	
Allergies to food?	<input type="checkbox"/>	<input type="checkbox"/>	List:	
Glasses?	<input type="checkbox"/>	<input type="checkbox"/>		
Speech difficulty?	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>		

Other health concerns:

.....

.....
Parent signature

.....
Date

DeWitt-Lavaca Special Education Cooperative
MEDICAL RELEASE



This authorization is provided in accordance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPPA"), which went into effect in April 2003.

The specified information will be used for the purposes of providing appropriate health care, classroom modifications, other campus activities, and emergency response.

.....
Last name, First name Middle name

.....
Physical address, City, State, Zip

.....
Mailing address, City, State, Zip (if different from above)

..... / /
Social Security number Birth date (MM/DD/YYYY) Primary phone number

.....
Mother/Guardian Relation Phone number

.....
Father/Guardian Relation Phone number

.....
Local family doctor: Phone number:

.....
Dentist: Phone number:

I, the undersigned, do hereby authorize the DeWitt-Lavaca Special Education Cooperative to contact directly the person named on this form, and authorize the named physician to render treatment as may be deemed necessary in an emergency, for the health of said child. I also give permission for the School Nurse to contact the above-named medical care providers with any questions regarding the health care of my child. The School Nurse can receive and send communication regarding any medical examination reports and conclusions, to and/or from the healthcare provider, when such knowledge would impact the healthcare of said child while attending school.

Right to revoke: I understand that I have the right to revoke this Authorization at any time by notifying the school, in writing. I understand that the revocation is only effective after it is received and logged by the School Nurse or authorized designee. I understand that I cannot revoke this Authorization to the extent that the school has taken action in reliance of this Authorization.

I understand that this Authorization is not required for the DeWitt-Lavaca Special Education Cooperative to use or disclose this information for purposes of treatment, or if the use or disclosure is otherwise permitted by the Privacy Standards, and that any revocation of this Authorization will have no effect on such uses or disclosures.

I understand that I am entitled to receive a copy of this Authorization.

.....
Parent signature

.....
Date

DeWitt-Lavaca Special Education Cooperative MEDICATION GUIDELINES



The DeWitt-Lavaca Special Education Cooperative (DLSEC) nurses and Unlicensed Assistive Personnel (UAP) are guided by Texas law when administering medication. When the nurse is not on campus, medications will be given by an UAP chosen by the Multi-District Programs Principal. Medication will be given at school under the following guidelines:

Medication must:

- be provided by the parent/guardian.
- be in the original package with the original label with dose specifications/directions (over-the-counter medications).
- have the current label with current information (prescription medications).
- be prescribed for the student it will be administered to (prescription medications).
- be delivered to school by the parent or guardian.
- be accompanied by written parent/guardian permission for administration. A new request is required each school year.
- be accompanied by written physician consent if given for more than 10 consecutive days.

Medication will **not** be given if:

- it is in loose or unlabeled packaging. If sent to school in this manner, it will be disposed of.
- it is from a foreign country.
- it is expired.
- it is an allergy shot.
- it is an herbal remedy or homeopathic product, unless it is required by the student's IEP or Section 504 Plan. In these instances, the remedy or product will be administered by an UAP.
- it can be given at home. This will be reviewed on an individual basis according to the needs of the student. Generally, medications ordered 3 times daily or less will NOT be given at school unless a specific time is ordered by the physician.

In accordance with the Board of Nurses, Rule 22 Texas Administrative Code, section 217.11, the nurse has the responsibility and authority to refuse to administer any medication that in his/her judgement is not in the best interest of the student.

When stored at school, medication will be kept in a secure location and administered from the school clinic. For special circumstances requiring self-carry or self-administration (such as epi-pens and inhalers), contact the Nurse Supervisor.

For questions regarding the DLSEC Medication Guidelines, please contact the DLSEC Nurse Supervisor at (361) 293-2854.

Parent: Please keep this page for your information.

DeWitt-Lavaca Special Education Cooperative
MEDICATION ADMINISTRATION REQUEST



.....
Student name:

..... / /
Birth date (MM/DD/YYYY)

PARENT/GUARDIAN PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Name of Medication:

Dose:

Route:

Frequency:

Time to be Given:

Special Instructions/Handling:

.....

I have read the attached medication guidelines and give the DeWitt-Lavaca Special Education Cooperative permission to administer the above-named medication as directed, as well as contact the physician for additional information as needed. I understand that:

- I must provide all medication.
- Medication must be provided in the original container with the label intact. Loose or unlabeled medication will not be administered by DLSEC employees.
- A new form must be completed for all medication changes and for each new school year.

.....
Parent signature

.....
Date

.....
Parent printed name

.....
Phone number

PHYSICIAN CONSENT FOR THE ABOVE-NAMED MEDICATION

Required for all medication (prescription and over-the counter) given for more than 10 consecutive days and all injectable medications.

Reason for medication:

.....
Physician signature

.....
Date

.....
Physician printed name

.....
Phone number

DeWitt-Lavaca Special Education Cooperative
VIDEO & PHOTOGRAPH PERMISSION FORM



The DLSEC would like to request parent/guardian permission to video tape and photograph students during the year to be used in making a portfolio, to share with other educators regarding multi-district programs, in the newspaper, the Cooperative's website for presentations explaining our programs and/or in recording activities for our classroom photographic albums. These photos may sometimes be used on bulletin boards or will be sent home to parents.

Check one:

- Yes, my child may be videotaped and photographed. My child's name may not be shared unless I have been contacted first.
- No, my child may not be videotaped or photographed.

Parent signature

Date

DeWitt-Lavaca Special Education Cooperative
PARENT'S RESPONSE REGARDING RELEASE OF STUDENT INFORMATION



For the following school-sponsored purposes: student recognition activities, yearbook or student newspaper, printed program for extracurricular activities, news releases to local media, and morning announcements, DeWitt-Lavaca Special Education Cooperative has designated the following information as directory information:

- Student's name
- Address
- E-mail address
- Grade level
- Photograph
- Enrollment status
- Student identification numbers
- Weight and height, if a member of an athletic team
- Date and place of birth
- Honors and awarded received
- Dates of attendance
- Most recent school previously attended

Please check one of the choices below for school-sponsored purposes:

- Yes, I **DO GIVE** the DLSEC permission to use the information in the above list for the specified school- sponsored purposes.
- No, I **DO NOT GIVE** the DLSEC permission to use the information in the above list for the school- sponsored purposes

Parent signature

Date



Student Agreement for Participation in the Electronic Communication System

.....
Student's full name

.....
Grade level

.....
Home district

I have read the DLSEC electronic communications system policy and administrative regulations and agree to abide by their provisions. I understand that violation of these provisions may result in suspension or revocation of system access.

Student signature (as appropriate)

Date

Sponsoring Parent or Guardian Agreement for Participation in the Electronic Communication System

I have read the DLSEC's electronic communications system policy and administrative guidelines. In consideration for the privilege of using the DLSEC's electronic communications system, and in consideration for having access to the public networks, I hereby release the DLSEC, its operators, and any institutions with which they are affiliated from any and all claims and damages of any nature arising from my child's use of, or inability to use, the system, including, without limitation, the type of damage identified in the DLSEC's policy and administrative regulations.

Please check one of the choices below:

Yes, I give permission for my child to participate in the DLSEC's electronic communications system and certify that the information on this form is correct.

No, I do not give permission for my child to participate in the DLSEC's electronic communications system.

Parent signature

Date

DeWitt-Lavaca Special Education Cooperative
COMMUNITY-BASED INSTRUCTIONAL TRIPS PERMISSION FORMS



The DLSEC would like to request your permission to transport your child for Community-Based Instructional (CBI) trips throughout the year in order to meet his/her IEP objectives in the Community Domain.

I give permission for my child, _____, to participate. Also, I give my permission for the above named child to be given emergency medical care at a hospital or health care facility in the presence of a DeWitt-Lavaca Special Education Cooperative employee or a Yoakum ISD employee in the case of an emergency during a CBI trip.

I further release from any liability concerning said trips, the Yoakum ISD and any of its employees.

Parent signature

Date