Columbus City Schools
Health, Family and Community Services
61 South 6th Street
Columbus Ohio 43215

Health forms for all students with **Allergies** that may need treatment at school

Please complete packet and return to nurse at child's school

What's in this packet?

1) Allergy Questionnaire to describe student's allergies
2) Release of Information allows the doctor to talk to the school nurse if there are any questions
3) In case the student uses an Epi-pen or similar medicine:
    - Guidelines for Medicines at School
    - Medication Authorization must be signed by parent and doctor and brought to school with the medication (for medications like Benadryl.)
    - Epinephrine Auto-injector Medication Authorization must be signed by the doctor and brought to school with the medication (for medications like Epi-pen.)
4) Special Diet Order for parent and doctor to sign in case the student has a food allergy that requires a special diet. For more information about what needs a special diet order, see **www.ccsoh.us/FoodService.aspx** and look for the Special Diets for Columbus City School District Students in the red column on the right.

Questions? Please contact your school nurse.

New, enrolling students, please contact:
Central Enrollment Center Nurse
Columbus City Schools Enrollment
(614) 365-4011 extension 2321

Allergy Questionnaire

To be completed by parent

Columbus City Schools
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Student Name_____ Date of Birth_____ School Year_____

School_____ HR / Grade_____

Current information indicates that this child has a history of allergies. To provide care while this child is at school, please complete the information below so the school nurse has a better understanding of the allergies.

Has this child been diagnosed with allergies/anaphylactic reactions by a healthcare provider? ☐ Yes ☐ No

Please list all of the child's allergies, including foods:

Does this child react to skin contact with the allergen? ☐ Yes ☐ No
If so, what is the reaction?

Does this child react to swallowing the allergen? ☐ Yes ☐ No
If so, what is the reaction?

How soon after exposure does this child react?

How does this child prevent and respond to an allergic reaction? (check all that apply)

- ☐ The child knows what to avoid
- ☐ The child asks about ingredients in food, if unsure
- ☐ The child tells others about his/her allergies
- ☐ The child will **immediately** tell an adult if exposed to an allergen
- ☐ The child can give their own injection with an Epipen if prescribed by their healthcare provider
- ☐ Other_____

What medical care was given in the past? (fill out all that apply)

- ☐ Cold compress (in cases of a sting)
- ☐ Oral medication: What was used? _____
- ☐ Injection: What was used? _____
- ☐ Treatment in doctor's office _____
- ☐ Treatment in the Emergency Room or your child was in the hospital?_____
- ☐ Other _____

Does this child wear an identifying tag or bracelet alerting others to the allergy? ☐ Yes ☐ No

Are medications required to be kept at school? ☐ Yes ☐ No **If yes, what kind?** _____

_____

(*All medications at school require the Medication Authorization to be on file*)

Any additional information? _____

Parent Signature _____ **Phone** _____ **Date** _____

PLEASE RETURN THIS FORM IMMEDIATELY TO THE SCHOOL NURSE.

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Authorization for Release of Immunizations and other Health Information

CHILD'S NAME _____ **DATE OF BIRTH** _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and Columbus City Schools.

Obtain Information From:

Please fill in as much as you know

Doctor _____

Clinic _____

Street Address _____

City _____ State _____

Phone _____ Fax _____

Release Information to: Columbus City Schools

Attention School Nurse _____

Fax_____

Medical Information/Records:

- ☐ **TB skin or TB blood test, chest x-ray report, and medication completion as appropriate**
- ☐ **Immunization record**
- ☐ **Other health information** _____

This authorization will remain in effect for 12 months after the date I sign it. The information released could be further released and no longer protected by privacy regulations. I understand that I may cancel this authorization at any time by sending a written request to the Columbus City Schools at the address above. This request will not apply to information already released.

*I hereby **CANCEL** the authorization as of this date:_____, signed_____.*

This information is requested for school enrollment.

✘ _____ _____

Parent/Guardian Signature Date

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Guidelines for Medications at School

Students needing to take medication during school hours must follow these guidelines:

- **Provide the school nurse with a completed Medication Authorization Form signed by both the parent/guardian and the healthcare provider.**

- **A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.**

- **All medication must be in the original container in which it was dispensed by the healthcare provider or pharmacy** and be labeled with the correct dose and instructions.
  - The label must match what is on the Medication Authorization Form.
  - Students taking a medication at both school and home can request 2 separate labeled bottles from the pharmacy to divide the pills to have some at home and school.
  - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from the healthcare provider in order to have a supply at home and school.

- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form must be completed.**

  Prescribed over the counter medications follow the same guidelines as stated above for prescribed medications. (Over the counter medications include pain medication such as Tylenol, cough medicine, ointments.)

- **Medications ordered three times a day or less, unless time is specified, may not need to be taken at school.** The medication should be given before school, after school and at bedtime.

All unused medication must be picked up by the parent/guardian on the last day of school or it will be discarded.

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Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School_____ HR/Grade _____

Healthcare Provider to Complete:

Columbus City Schools urges scheduling doses for times outside of school.

I verify the above student should receive this medication at school for treatment of_____

Medication_____ Dosage_____ Route_____

Administration Time(s)_____ Beginning Date _____ Expiration Date_____ /end of school year

Instructions, precautions, and possible side effects_____

_____

Other medications prescribed to this student (home & school) _____

_____

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address_____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Columbus City School Health Services staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____

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Epinephrine Auto-Injector Medication Authorization

to access and use prescribed medications during school
ONE FORM PER MEDICATION

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School_____ HR/Grade _____

Healthcare Provider to Complete:

I verify this medication has been prescribed for above student in the event of signs or symptoms of an allergic reaction and/or suspected exposure to the following allergen(s): _____

Signs or symptoms _____

Medication_____ Dosage_____ Route_____

Beginning Date _____ Expiration Date_____ or end of school year

CALL 911 when medication is administered. Repeat dose if medication does not produce relief ☐yes ☐no

Other medications prescribed to this student (home & school) _____

THIS SECTION IS ONLY FOR THE PERMISSION TO SELF CARRY:

I provided the student with training in the use of an auto-injector and he/she has demonstrated its proper use. ☐ yes ☐ no

The student is capable of possessing and self-administering the auto-injector per ORC 3317.716 and 3313.718. ☐ yes ☐ no

Per state law, I prescribed a back-up auto-injector to be kept at school for as needed use by trained staff. ☐yes ☐no

Healthcare Provider Signature_____ **Date**_____

Provider Name _____

Practice Address _____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

Parent/Guardian Name_____ **Phone Numbers** _____ **or** _____

To the Parent or Guardian: The following information is necessary for any student who uses medication in school.

- **Both the parent and healthcare provider portions of this form must be completed**.
- A new Medication Authorization form is required each school year and when there is a change in the medication.

- I authorize the student named above to have access to and use the medication as ordered above.
- I understand my student's epinephrine auto-injector will be stored in the school medication cabinet to ensure its availability and will have the assistance of trained staff as needed.
- If my student is determined capable to self-carry and self-administer by myself, the healthcare provider and the school nurse, then I authorize my student to carry and use their epinephrine auto-injector as prescribed above, at school and school events: ☐yes ☐no.
  - I will instruct my child to inform school staff if he/she has used the auto-injector so school staff can immediately call 911.
  - I agree to provide the school with backup dose of epinephrine as required by law.
- I understand emergency medical service will be called if the epinephrine auto-injector is used. I understand the medication must be in the original container and properly labeled with student's name, date, prescriber's name, name of medication, dosage, strength, route and time of administration and drug expiration date.
- I assume responsibility for the safe delivery of the medication to school and will notify the school immediately with any medication changes.
- I authorize Columbus City School Health Services staff to communicate with the student's healthcare provider as needed.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature _____ **Date**_____

Special Diet Order

Federal regulations require diet orders
to be submitted by October 1st of **each** school year
or when orders change.

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Please provide the following special diet instructions for:

Student Name_____ Date of Birth_____ School Year_____

School_____ HR / Grade_____ Preschoolers Only: ☐ Morning session ☐ Afternoon session

Parent/Guardian Signature_____ Date_____

Healthcare Provider to Complete:

Diagnosis/Allergen:

Diet order: Please specify restricted foods if indicated.

PLEASE NOTE – for students with severe nut allergy, Columbus City Schools purchases foods from manufacturers that may share equipment, and may use the same facilities that process nuts. Advise parents and school accordingly if the above student with severe nut allergies will need to pack their breakfast and lunch.

Healthcare Provider Signature _____ Date _____

Provider Name _____

Practice Address _____

_____

Phone_____ Fax _____

Please fill contact information to left or stamp here

PLEASE return this form to _____ 614-365-_____ 614-365-_____
Licensed School Nurse Phone Fax

School Nurse: Fax to the Food Service Department