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

Health forms for all students with

Seizures

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

What's in this packet?

1) Seizure Questionnaire to describe student's seizures
2) Release of Information allows the doctor to talk to the school nurse if there are any questions
3) In case the student uses Diastat (diazepam):
    - Diastat Administration Guidelines for parent to sign
4) In case the student uses nasal Versed (midazolam):
    - Versed Administration Guidelines for parent to sign
5) Guidelines for Medicines at School
6) Medication Authorizations must be signed by parent and doctor and brought to school with the medication (one copy per medication)

Questions? Please call your school nurse.

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

QUESTIONNAIRE FOR PARENTS OF STUDENT WITH SEIZURE DISORDER

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

Student Name	DOB	ID#	School	Grade/Rm	Acad.Yr.
Parent/Guardian Name		Best Phone Numbers			
Parent/Guardian Name		Best Phone Numbers			
Health Care Provider Name		Phone Number			

The following information will be helpful to the school nurse and school staff in determining your child's special needs. Questionnaire form is to be updated and completed each school year. Thank you.

Seuzure Information

Seizure Type	Length	Frequency	Description

What happens during the seizure?

How long has your child had seizures?	What triggers the seizure?

Are there any warning or behavior changes before the seizure? ☐ **yes** ☐ **no** If yes, please explain:

How long does the seizure last?	What time of day do the seizures usually happen?
How often do the seizures usually come?	What was the date of the last seizure?

How do other illnesses affect your child's seizure control?

Medication	Dose & Time	Medication	Dose & Time

Student has a Vagus Nerve Stimulator (VMS)? ☐ **yes** ☐ **no** If yes, describe use:

Special considerations & safety precautions for school activities:

☐ General health ☐ Gym/ sports (physical activity) ☐ Physical functioning ☐ Learning ☐ Field trips
☐ Recess ☐ Bus transportation ☐ Mood / coping ☐ Behavior ☐ Other

Explain:

What happens when your child misses a dose of seizure medication?

Are there any other recurring or chronic health problems?

Any other information you feel would be helpful for the teacher or nurse to know?

I authorize Columbus City School to communicate with the student's teacher, principal, vice principal, school nurse and other school personnel about the seizures.

Parent's signature **Date**

Authorization for Release of Immunizations and other Health Information

Columbus City Schools
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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.

Medication Authorization for DIASTAT or MIDAZOLAM (Versed)

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

Student Name_____ Date of Birth_____ School Year_____

Home Address_____ School_____ HR/Grade _____

Healthcare Provider to Complete:

I verify the above named student should receive this medication and recommend and approve the following procedure(s) to be followed in administering this medication to this student during school:

Order: Give _____ _____ _____ _____
Medication Dose Route Frequency

For _____ lasting _____ or has _____ seizures in _____.
Type of seizure Minutes Number Time frame

Beginning Date _____ Expiration Date_____ or end of school year

Following administration of medication - possible side effects include_____

_____

Following administration – these actions should occur_____

If not resolved after the first dose the following should occur_____

This medication will only be administered by a licensed school nurse, the parent/guardian, or emergency medical services personnel. If a seizure occurs that requires this medication and the nurse or parent/guardian is not present, 911 will be called. A new order is required at the beginning of each school year.

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 receive the medication as ordered above and understand the school nurse is the only district staff permitted to administer this medication.
- 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 understand if the school nurse is unavailable and the need for this medication occurs that EMS and myself will be called.
- 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**_____

Medication Authorization

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

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

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**_____

Please fill contact information to left or stamp here

Provider Name _____

Practice Address_____

_____

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**_____