Health, Family and Community Services
Columbus, Ohio 43215

Health forms for students with

Asthma

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

What is in this packet?

1) Asthma Questionnaire to describe student's asthma

2) Release of Information allows the doctor to talk to the school nurse if there are any questions

3) Guidelines for Medicines at School – parent reference

4) Asthma Medication Authorization - must be signed by parent and doctor and brought to school with the asthma medication

5) Medication Authorization - must be signed by parent and doctor and brought to school with any additional medication

Questions - Please call your school nurse.

Health, Family and Community Services
Columbus, Ohio 43215

Asthma Questionnaire

To be completed by parent

Student Name_____ Date of Birth_____ School Year_____

School_____ HR / Grade_____

Parent/Guardian _____ Phone_____

Parent/Guardian _____ Phone_____

Emergency Contact_____ Relationship_____ Phone_____

Emergency Contact_____ Relationship_____ Phone_____

Healthcare Provider_____ Phone_____ Fax_____

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

Asthma Triggers - circle and describe:

Exercise Illness Weather Smoke/Fumes/Odors Animal_____ Other_____

Indoor allergies_____

Outdoor allergies_____

Other_____

Early Symptoms or Warning Signs

Please list:

Asthma Medicine

Typically, how often does your child need to use a rescue medication?

How does your child manage an asthma episode at home?

☐ rescue inhaler ☐ nebulizer ☐ other_____

Daily medication name:	**Dosage:**	**When taken:**
"As needed" or rescue medications:	**Dosage:**	**When used:**
☐ Albuterol MDI	90mcg 2 puffs	every four hours as needed
☐ Other:		

What should school personnel do to help your child during an asthma episode?

☐ allow to rest and cool down ☐ give sips of water ☐ give rescue inhaler as ordered

☐ other_____

If the student does not respond to medication during as episode, the school will notify the parent/guardian and call 911

Any other information or chronic health problems that would be helpful to know? _____

I authorize Columbus City Schools to communicate with the student's healthcare providers, teachers and other appropriate school staff about the asthma.

Parent Signature_____ *Date*_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Health, Family and Community Services
Columbus, Ohio 43215

CHILD'S NAME: _____

DATE OF BIRTH: _____ **STUDENT #:**_____

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: _____
_____
_____

_____ Release Information To: _____
_____
_____

_____ Medical Information/Records

_____ TB Test Results/Records

_____ Immunization Records

_____ Achievement and Aptitude Test Scores

_____ Psychological Information/Records

_____ Grades and Attendance

_____ Speech and/or Hearing Evaluation

_____ Individual Education Plan (IEP), if in Special Education

_____ Other Information, as specified: _____
_____
_____

This information to be used for: _____

_____ _____
Parent/Guardian Signature Date

COLUMBUS CITY SCHOOLS

Guidelines for Medications at School

Health, Family, and Community Services
Columbus, Ohio 43215

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.***

Asthma Medication Authorization

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

Health, Family and Community Services
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**_____

Frequency: ☐ Every _____hours PRN **- OR -** ☐ Give at: _____ (time/s) **Begin Date** _____**End Date** _____or End of school year

Instructions and precautions_____

Possible side effects to report to the healthcare provider_____

If the medication does not provide relief_____

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

For asthma inhaler: The student has demonstrated the proper use of the medication? ☐yes ☐no
The student is capable and may carry and self-administer medication per ORC 3317.716 and 3313.718. **☐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 inhaler will be stored in the school medication cabinet to ensure its availability for their use and will have the assistance of trained staff as needed unless he/she is authorized to self-carry and administer.
- 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.
- **My student may self-carry and self-administer his/her inhaler as prescribed above, at school/school events if determined capable by myself, healthcare provider and school nurse and understand my student is to report to school clinic/office after using medication. ☐yes ☐no**

Parent/Guardian Signature _____ **Date**_____

Medication Authorization

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

Health, Family and Community Services
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)_____ OR ☐ Every _____ hours as needed for_____

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_____

_____

Phone_____ Fax _____

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.

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Parent/Guardian Signature _____ **Date**_____