Health, Family and Community Services
Columbus Ohio 43215

Health forms for students with

# Allergies

**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) If the student needs an Epi-pen or similar medicine at school:

   - Guidelines for Medicines at School– parent reference
   - 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 parent and the doctor and brought to school with the Auto-Injector.

4) Special Diet Order - if needed – is signed by parent and doctor 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 call your school nurse.**

COLUMBUS CITY SCHOOLS

# Allergy Questionnaire

*To be completed by parent*

Health, Family and Community Services
Columbus, Ohio 43215

Student Name _____ Date of Birth _____ School Year _____

School _____ HR/Grade _____

Parent/Guardian _____ Relationship _____ Phone _____

Parent/Guardian _____ Relationship _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Healthcare Provider _____ Phone _____ Fax _____

***This information will provide the school nurse with a better understanding of the child's needs. This questionnaire needs updated and completed each school year.***

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

**Note:** Bring medical documentation to the school nurse. **AFTER** the nurse has received documentation from the child's **healthcare provider,** school staff will be notified of the allergies and emergency plans.

| List all allergies, including foods | Child reacts to allergen if: Circle | Describe allergic reaction: | How long does it take to react? |
|---|---|---|---|
| | **swallows touches inhales** | | |
| | **swallows touches inhales** | | |
| | **swallows touches inhales** | | |
| | **swallows touches inhales** | | |
| | **swallows touches inhales** | | |
| | **swallows touches inhales** | | |
| | **swallows touches inhales** | | |

**Prevention:** **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 other about his/her allergies
☐ The child will immediately tell an adult if exposed to an allergen
☐ **The child wears an identifying tag or bracelet alerting others to the allergy**
☐ Other:

**Allergy Response:**

**Has this child ever needed to use an epinephrine auto-injector (Epipen):** ☐ **Yes** ☐ **No** **If yes, date of last injection:** _____

| **Are medications needed AT SCHOOL?** ☐ **Yes - List** ☐ **No** | **Dose:** | **Time:** |
|---|---|---|
| ***IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.*** | | |
| | | |
| | | |
| **Allergy medication AT HOME:** ☐ **Yes - List** ☐ **No** | **Dose:** | **Time:** |
| | | |
| | | |

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

**Parent/Guardian Signature** _____ **Date** _____

***RETURN TO SCHOOL NURSE IMMEDIATELY***

# AUTHORIZATION FOR RELEASE OF INFORMATION

**Date:**

| | | | |
|---|---|---|---|
| **Student Name:** | | **Birth Date:** | |
| **School Name:** | | **School Phone:** | |
| **Requested by: (CCS Staff)** | | **School Fax:** | |

In order to release any confidential information regarding your student, Columbus City Schools is required by law to have your written permission as this information is protected under the Family Educational Rights and Privacy Act (FERPA). Please sign this form to indicate the agencies or individuals that Columbus City Schools may receive information from or release information to regarding your student. Please keep a copy for your records. This signed authorization will be valid for one year from the date of your signature. If you wish to revoke this consent, please provide written notice to your student's school.

*Please indicate the name, address and phone number of the providers that CCS may request from or send information to. Make sure to un-check any information you do NOT wish to be shared.*

| OK to Request data | Ok to Send data | Provider Name | Provider Address | Provider Phone |
|---|---|---|---|---|
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |
| ☐ | ☐ | | | |

I understand the requested information below will be used by the Columbus City School staff for educational and health care planning and service delivery: **Please un-check any information you do NOT wish to be shared.*

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Medical Information/Records | ☐ | Psychological Information/Records | ☐ | Immunization Records |
| ☐ | TB Test Results/Records | ☐ | Speech and/or Hearing Evaluation | ☐ | School Health Records |
| ☐ | Other information, as specified: | | | | |

I understand any release of information pertaining to substance abuse, mental health or HIV related records will be done only if needed to better meet the educational and school health needs of the student named above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above-mentioned entity. Release of alcohol and drug abuse information is protected by Federal Confidentiality Rules (42 CFR Part 2) without written consent of the person to whom it pertains or as otherwise permitted. Federal rules also restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52 FR 21809, June 9, 1987: 52 FR 41997, November 2, 1987).

**Authorization for Redisclosure**: Under federal law, CCS may not redisclose the information identified above to any other party without prior consent.

**Parent/Guardian or Adult Student Signature** **Date**

**Printed Name of Parent/Guardian or Adult Student**

Health, Family and Community Services
Columbus Ohio 43215

# 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.***

COLUMBUS CITY SCHOOLS

# 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_____Strength/Concentration_____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**_____

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.
- I understand the medication must not be expired, be in the original container and 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**_____

COLUMBUS CITY SCHOOLS

# Epinephrine Auto-Injector 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:

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**_____**Strength/Concentration**_____ **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**_____

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Columbus Ohio 43215

# Special Diet Order

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