School Year 2025-2026

Dear Parent or Guardian,

Welcome back! We're thrilled for another exciting school year and can't wait to see all our students achieve great things.

Please complete and return the required health forms. You can pick these up at the school or find them online at: https://www.cps-k12.org/our-students/forms.

Here's a quick rundown of the important forms:

- **Emergency Medical Authorization**: This form allows us to get emergency treatment for your child if they become ill or injured at school and we can't reach you.
- **Health History Update**: Ohio law requires this form every school year. It provides us with important health information about your child.
- **Additional Forms for Chronic Conditions**: If your child has a chronic condition like asthma, diabetes, or a seizure disorder, please get additional forms from your school's health office.

Medication Forms (*Only complete these if your child needs medication during school hours*):

- CPS Administration of Prescription Medication
- CPS Administration of Over-the-Counter Medication

Please note: Both medication forms require signatures from both the healthcare provider and the parent/guardian.

If you would like your child to receive services from any of our **School Based Health Centers**, please fill out the appropriate consent form:

- Cincinnati Children's Hospital Medical Center *(Hughes, Rockdale, South Avondale)*
- Cincinnati Health Department *(AWL, Aiken, Ethel Taylor, JP Parker, Mt. Airy, Oyler, Riverview East, Roberts, Roll Hill, Shroder HS, Taft HS, West High/Dater HS, Withrow)*
- Crossroads *(Rothenberg, Taft Elementary)*
- Mercy *(Sayler Park)*
- WinMed *(Bond Hill, Winton Hills, Woodward)*

Thank you for taking care of these important documents and for helping us keep your child healthy!

Angie Maddox
School Health Manager

Health History Update - 2025-2026

Please fill out and return to the school health office. Thank you.

Ohio law requires that a current Health History form be on file for every student.

_____ _____ _____/_____

Student's Name Date of Birth Grade/Homeroom

_____ _____ _____

Doctor's Name Phone Number Last checkup or visit

_____ _____ _____

Dentist's Name Phone Number Last checkup or visit

Insurance: ____Medicaid (Circle one: CareSource/ Molina/ United Health Care/ Paramount/ Buckeye)

____Private Insurance Provider's Name_____

____None

Any history of the following problems? (Circle Y for YES or N for NO)

History For Student and then Family	Student	Family
Allergies: Seasonal/Hay fever	Y N	Y N
Life Threatening Allergy to:_____ EpiPen prescribed	Y N Y N	
ADD/ADHD	Y N	Y N
Anemia or Other Blood Problems	Y N	Y N
Asthma	Y N	Y N
Behavioral Problems _____	Y N	Y N
Blood Pressure Problems (High/Low)	Y N	Y N
Developmental Problems _____	Y N	
Cancer – type _____	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N
Chronic Ear Infections	Y N	
Depression	Y N	Y N
Diabetes	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N	
Eczema/Chronic Skin Condition	Y N	Y N

History For Student and then Family	Student	Family
Emotional/Psychological Problems	Y N	Y N
Frequent Headaches Head Injury/Concussion? When_____	Y N Y N	Y N
Frequent Stomachaches	Y N	Y N
Hearing Problems	Y N	Y N
Heart Disease – type _____	Y N	Y N
Kidney Disease – type _____	Y N	Y N
Learning Problems _____	Y N	Y N
Prematurity or Birth Weight under 5 lb.	Y N	
Seizure Disorder/Epilepsy/Tics	Y N	Y N
Sickle Cell Disease	Y N	Y N
Sleep Problems	Y N	Y N
Speech Problems	Y N	Y N
Toothaches/Dental Problems	Y N	Y N
Problems with Vision Wears Glasses	Y N Y N	Y N
Surgery? What type?_____	Y N	

Tuberculosis (TB) Risk Assessment:

Is your child in contact with any of the following people: Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?

For your child, please circle Yes or No below, and explain any Yes answers.
Diagnosed or treated for TB? ___No ___Yes _____
Immigration from another country? ___No ___Yes _____
Traveled to another country? ___No ___Yes _____
Ever been in jail or in 2020 (Juvenile Detention Center)? ___No ___Yes

Student's Name_____

Has your child received the COVID-19 Vaccine? ___No ___Yes Dates: _____

Please list any **CURRENT** health problems or conditions your child has (may be same as above): _____
_____

Please list any allergies (include **food, medications**, **environmental, seasonal, etc.**):
_____

Please list any dietary restrictions (medical or non-medical) _____

Does your child see a specialist? Yes____ No____If yes, please list condition, doctor's name, and phone number:

_____

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches): _____

_____

SPECIAL NOTE: If your child must take any medications at school, including emergency medications (such as an inhaler or Epi Pen), you must fill out a CPS Administration of Medication form (available at the school).
Has your student had any operations, serious injuries or overnight hospital stays? No___Yes ____; please explain:

_____

Has your child ever been pregnant? No ___Yes ____; please explain:
_____

Has your child ever been a victim of abuse? No ___Yes ____; please explain:

_____

Has anything bad, scary or sad happened to your family? No ___Yes ____; please explain:

_____

School Concerns

Is your child in a special education class? No ___Yes ____; please explain: _____

Has your child repeated a grade? No ___Yes ____; details: _____

Does your child get into trouble at school? No ___Yes ____; details: _____

What are your child's grades on the report card? _____

Any changes recently in grades? No ___ Yes ___

Name of Parent/Guardian _____ Date _____

How can we reach you during school hours? Cell:_____ Work_____ Other_____

Emergency Medical Authorization Form

Fill out this form and return it to your child's school.

Student's Name: _____ ID #: _____ Homeroom: _____ Birth Date: _____

School: _____ Grade: _____ Year: _____

Student's Address: _____ Apt.: _____ Phone: _____

City: _____ State: _____ Zip: _____

Purpose — To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Parent / Guardian Name:_____ Daytime Phone:_____

Parent / Guardian Name: _____ Daytime Phone:_____

Other's Name: _____ Daytime Phone:_____

Name of Relative or Child-care Provider: _____

Relationship: _____ Daytime Phone:_____

Address: _____ Zip: _____

PART I <u>or</u> PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical-care providers and local hospital to be called:

Physician: _____Phone: _____

Dentist: _____Phone: _____

Medical Specialist:_____Phone: _____

Local Hospital: _____ Emergency Room Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Zip: _____

PART II: REFUSAL TO GRANT CONSENT I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school to take the following action:

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____Zip: _____

Cincinnati Health Department

School-Based Health Center Enrollment Packet

PLEASE COMPLETE AND SIGN ALL PAGES.

STUDENT/PATIENT'S NAME: _____ **DOB:** ___/___/____ **Gender: M/F Trans: MTF/FTM or Non-Binary**

Child's Social Security #: _____-_____-_____ Medical Card/Insurance ID: _____

☐ CareSource ☐ Molina ☐ Buckeye ☐ Paramount ☐ United Health Care ☐ No Insurance ☐ OTHER _____

MEDICAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **MEDICAL CARE** including routine well childcare* (e.g. work, daycare, and sports physicals) appropriate immunizations, fluoride varnish and treatment for illness or injury including over the counter medications unless emergency services are needed. (*Note: well child care includes vision/hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate).
My child may be **TRANSPORTED/ACCOMPANIED** to and from medical services by a school designee. I, the parent or guardian of above-named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and the Cincinnati Public School District (CPS), its board personal injury or damage resulting from the transportation of my student to and from health services. ***Please note: in Ohio, minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.***

☐ **NO,** I do not wish for my child to receive **MEDICAL CARE** at the school-based health center (SBHC)

DENTAL HEALTH CARE SERVICES:

☐ **YES,** I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Center or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from dental services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO,** I do not wish for my child to receive **DENTAL SERVICES**

EYE CENTER SERVICES:

☐ **YES,** I consent for my child to receive **EYE CENTER SERVICES** at the OneSight Vision Center at Oyler School or Academy of World Languages, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from eye center services by a school designee. I, the parent or guardian of above named student, release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and CPS, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

☐ **NO**, I do not wish for my child to receive **VISION SERVICES**

⇨ _____ _____ _____

Parent / Guardian Signature (or patient if 18 or older) **Parent/Guardian Name** (PRINT) **DATE**

Phone (best) _____ Phone #2_____ Phone #3_____

_____ _____ _____

ADDRESS STREET APT CITY STATE ZIP

I give consent for my child to obtain the services that I have marked in the boxes above. I agree to the terms and conditions regarding the PAYMENT FOR SERVICES and SHARING OF HEALTH INFORMATION as explained in Program Description form (attached). **Consent in effect until terminated in writing** by Parent/Guardian.

STUDENT/PATIENT'S NAME: _____ DOB: ___/____/____

To provide health services for your child we need the following information:

Parent/Guardian Name: _____ Parent/Guardian's Date of Birth: _____

Relationship to Child: _____ Parent/Guardian's Social Security No.: _____

Address: _____ City/State/ZIP: _____

Emergency Contact Person: _____ Phone Number: _____

Your Child's Health History

- Do you have a **Primary Care Doctor**? ☐ YES ☐ NO
  Doctor Name/Clinic: _____ Phone #: _____ Fax #:_____
  Date of last complete yearly physical examination (head to toe): _____

- Do you have a **Primary Dentist?** ☐ YES ☐ NO
  Dentist Name/Clinic: _____ Phone #: _____ Fax #:_____
  Date of last routine dental check-up: _____

- Do you have a **Primary Eye Doctor?** ☐ YES ☐ NO
  Eye Doctor Name: _____ Phone #: _____ Fax #:_____
  Date of last routine vision exam: _____

- Do you have a **Preferred Pharmacy?** ☐ YES ☐ NO
  Preferred **Pharmacy**: _____ Phone #: _____ Fax #:_____

Please list any **CURRENT** health problems or conditions your child has:

Please list any **allergies** (include **food, medications**, environmental, seasonal, etc.):

Does your child see a specialist? If yes, please list condition, doctor's name, and phone number:

Please list any medications (prescribed or over-the-counter) your child takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches):

****SPECIAL NOTE: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you must complete a CPS Administration of Medication form****

Has your child had any operations, serious injuries, or hospitalizations? ☐ No ☐ Yes
Please provide reason and dates: _____

Has your child ever been pregnant? ☐ No ☐ Yes If *Yes*, how many living children has your child given birth to: _____

Has your child been a victim of abuse? ☐ No ☐ Yes

Has anything bad, scary or sad happened to your family? ☐ No ☐ Yes
Please explain: _____

School Concerns: Explain any YES answers on the line provided.

Is your child in a special class (Special Ed / IEP / 504 Plan)? ☐ YES ☐ NO _____
Has your child repeated a grade? ☐ YES ☐ NO _____
Does your child get into trouble often at school? ☐ YES ☐ NO _____
What are your child's grades? _____ ***Is this a change?*** ☐YES ☐ NO

(Please continue to the next page)

Cincinnati Public Schools

Health History Update:

Please complete and return to the school nurse or office. Thank you.
Ohio State Law requires that a Health History form be on file for every student.

_____ _____ _____/_____
Student's Name Date of Birth Grade/Homeroom

_____ _____ _____
Doctor's Name Phone Number Last checkup or visit

_____ _____ _____
Dentist's Name Phone Number Last checkup or visit

Insurance: ____Medicaid (circle: CareSource/ Molina/ United Health Care/ Paramount/ Buckeye)

____Private Insurance Provider Name_____

____None

Any history of the following problems? (Please circle **Y** for Yes or **N** for No)

History For Student and then Family	Student	Family	History For Student and then Family	Student	Family
Allergies: Seasonal/Hay fever	Y N	Y N	Emotional/Psychological Problems	Y N	Y N
Life Threatening Allergy to: _____ EpiPen prescribed	Y N Y N		Frequent Headaches Head Injury/ Concussion	Y N Y N	Y N
ADD/ADHD	Y N	Y N	Frequent Stomachaches	Y N	Y N
Anemia or Other Blood Problems	Y N	Y N	Hearing Problems	Y N	Y N
Asthma	Y N	Y N	Heart Disease – type _____	Y N	Y N
Behavioral Problems _____	Y N	Y N	Kidney Disease – type _____	Y N	Y N
Blood Pressure Problems (High/Low)	Y N	Y N	Learning problems _____	Y N	Y N
Developmental Problems _____	Y N		Prematurity or Birth Weight under 5 lb.	Y N	
Cancer – type _____	Y N	Y N	Seizure Disorder/Epilepsy/Tics	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N	Sickle Cell Disease	Y N	Y N
Chronic Ear Infections	Y N		Sleep Problems	Y N	Y N
Depression	Y N	Y N	Speech Problems	Y N	Y N
Diabetes	Y N	Y N	Toothaches/Dental Problems	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N		Problems with Vision Wears Glasses	Y N Y N	Y N
Eczema/Chronic Skin Condition	Y N	Y N	Surgery what type:_____	Y N	

Tuberculosis (TB) Risk Assessment:

Is your student in contact with any of the following persons: Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?

For your student/student, please circle yes or no below, and explain any yes answers in space provided.

Diagnosed or treated for TB? ___ No ___Yes _____
Immigration from another country? ___ No ___ Yes _____
Traveled to another country? ___ No ___Yes _____
Ever been in jail or in 20/20 juvenile center? ___ No ___ Yes_____

Has your child received the COVID-19? Yes No

Consent for Nitrous Oxide Sedation

Patient Name:_____

If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting – we suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating and patient may get red or flushed.
3. An unusually high amount of saliva is sometimes produced.
4. Although not common, a patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections (“Novocaine”). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be “asleep” and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and a parent can be present as well if requested.

If you would like to be present, please make a note on the top of this form and we will be happy to schedule an appointment for you at your convenience.

☐ I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

☐ I do not consent for my child to receive nitrous oxide sedation.

⇨ _____

Signature (Parent/Guardian) Phone Number Date

PLEASE REVIEW THE FOLLOWING INFORMATION

Program Description

School-Based Health Center

Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child at one of school-based dental centers located at Academy of World Languages, Withrow High School, Western Hills High School, Oyler School, Crest Smiles Shoppe, or other CHD Health Centers. If you have any questions or need help with the application, please call the School Health Program 357-2809 or contact your school nurse

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex; or sexual orientation.
- To have a health care assessment and plan of care and participate in your health care plan.
- To talk to your health care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow 30 days for completion of insurance or disability forms..
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency call 911 or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call 357-7320.

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.
- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid, you can stop by our center or call 513-357-2787.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact you for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.
- Dates of service regarding completed dental, vision and medical care (ie. Immunizations, annual well-child check and asthma care) may be shared with your child's school if you agree and sign the Authorization form provided with this consent.

I have the right to receive or review a copy of the Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Notice of Privacy Practices:

⇨ I have received or reviewed a copy (signature and date) _____

I do not want a copy (signature and date) _____

I authorize the SBHC to call my home or cell phone number and leave a message with an adult that answers the telephone or on the voicemail pertaining to my child's medical care, including laboratory results.

city of CINCINNATI HEALTH DEPARTMENT

We know health matters

INFORMED CONSENT FOR SILVER DIAMINE FLUORIDE

Silver diamine fluoride (SDF) is an antimicrobial liquid used to treat tooth sensitivity and to help stop tooth decay. Reapplication of SDF may be necessary to better control caries progression and is recommended every 3, 6 or 12 months but may be applied more frequently if needed. Treatment with SDF may not eliminate the need for dental fillings or crowns to repair function or esthetics. Additional procedures may incur a separate fee.

Facts for consideration:

- The procedure involves: 1) Proper isolation of the area and drying of affected teeth. 2) Rub a small amount of SDF on the decayed area. 3) Allow SDF to act on the tooth surface for at least 1 min, preferably up to 4 minutes. 4) Rinse tongue and oral mucosa.
- I should not be treated with SDF if: 1) I am allergic to silver or ammonia. 2) There are painful sores or raw areas on my gums or anywhere in my mouth (i.e., ulcerative gingivitis, gingivostomatitis).

Benefits of SDF treatment:

- It is quick, easy and painless.
- No need to numb teeth.
- It arrests 80% of cavities when applied twice yearly.
- It can help relieve tooth sensitivity.
- It is a temporary treatment option for young, fearful, or special needs patients that may require sedation for extensive dental care.

Risks related to SDF:

- **The affected area will stain black permanently.** Healthy tooth structure will not discolor. Stained tooth structure can be covered with a filling or a crown in the future.
- If accidently applied to the skin or gums, a brown or white stain may appear that causes no harm, cannot be washed off, and it will disappear in a few days to 2 weeks.
- You may notice a very temporary metallic aftertaste.
- SDF may not work for all cavities and decay will progress with poor oral hygiene and food impaction. In that case, the affected tooth will require further treatment, which can involve a filling or a crown, root canal therapy, extraction, or referral for specialty dental care.

Alternatives to SDF, not limited to the following:

- No treatment, which may lead to progression of cavities, severe pain and more serious dental infection.
- Depending on the location and extend of the tooth decay as well as the level of patient behavior and cooperation, other treatment may include fluoride varnish, a filling or crown, extraction, or referral to a specialist.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner. I have seen the photo displaying the discoloration of the cavity after SDF application. I consent to have Silver Diamine Fluoride (SDF) treatment with a dentist or another qualified dental staff at any dental site operated by the Cincinnati Health Department.

Patient Name: _____ Date of Birth:_____

Patient/Guardian Signature:_____ Date:_____

CHD Dental Staff Signature: _____ Date:_____

Authorization for Administration of Over-the Counter Medications at School

This form expires at the end of the current school year (2025-2026).

Student's Name _____ Date of Birth _____ School Year _____

Street Address _____ Apt. No. _____ City _____ State _____ Zip _____

School _____ Grade _____ Homeroom _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. *Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician / Nurse Practitioner / Dentist) *Complete dosage and frequency above.

Provider's Signature:_____Date: _____

Provider's Name:_____ Emergency Phone _____

I give permission to the Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

Signature of Parent or Guardian _____ Date _____

Please Print Name of Parent or Guardian _____

How can we reach you during school hours?

Work Phone _____ Cell Phone _____ Home Phone _____ Other _____

Authorization or Administration of Prescription Medication Form

This form expires at the end of the current school year (2025-2026).

Parent/Provider Request for School Personnel to Give Prescription Medicine

School:_____Grade:_____Homeroom:_____School Fax: _____

Cincinnati Board of Education policy, Section 5330, requires consent of the parent, guardian, or eligible student 18 years or older before medication (including prescription medication, inhalers, Epinephrine, etc.) can be given to a student by school personnel. The following information is necessary to comply with this policy. **Please answer all questions and return this completed form to your student's principal or school health office.**

Student's Name:_____Date of Birth:_____Home Phone: _____

Street Address:_____Apt. #:_____City:_____State:_____Zip: _____

TO BE COMPLETED BY THE STUDENT'S PROVIDER (Physician / Nurse Practitioner / Dentist)

Name of Medication:_____Dosage:_____

Time/Frequency:_____How Administered:_____Date to Begin: _____

Permission for this medication is only valid through the end of the current school year unless otherwise noted. EXCEPTION: For emergency medications for asthma, anaphylaxis, seizures or diabetes, this permission can be valid for 3 years. A provider order is required for any changes in this medication.

Date to Terminate Emergency Medication: _____ (3 years)

Please attach an emergency action plan with procedures to be followed if emergency medication does not alleviate student's emergency.

For Epinephrine orders only: I have determined that this student is capable of possessing and using this auto injector/epipen appropriately and have provided the student with training in the proper use of the auto-injector.

Severe reactions that should be reported to the physician: _____

Special conditions for storage of drug: _____

Provider's Signature:_____**Date:**_____

Provider's Name:_____**Emergency Phone #:** _____

TO BE COMPLETED BY THE STUDENT'S PARENT OR ELIGIBLE STUDENT

The medicine must be in pill, capsule, liquid, auto-injector or inhaler form, and must be clearly marked from the pharmacist. The label must show the student's name, medication name, dosage directions, doctor, and prescription number.

Pharmacy:_____Phone Number: _____

As the parent/guardian of this student (or eligible student), I give permission for the principal or designee to administer the prescribed medication. The undersigned agrees not to file or make any claim for negligence in connection with the administration or non-administration of this medicine(s) and further agrees to hold them harmless from any liability incurred as a result of the administration or non-administration of any medicines. I will inform the school if there is a change in any of this information.

Please check the following if applicable:

For Students with Asthma:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student (or myself) to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school participates.

For Students with EpiPen/Twinject/Auto Injector:

_____ As the parent/guardian of this student, or myself, an eligible student, I authorize the student to possess and use an Epinephrine Auto-Injector, as prescribed, at the school and any activity, event, or program in which the student's school participates. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered**. I will provide a backup dose of the medication to the school as required bylaw.**

Name of Parent / Guardian / Eligible Student (please print):

_____

Signature of Parent / Guardian / Eligible Student:_____**Date:**_____

Primary Emergency Phone: _____**Secondary Emergency Phone:** _____

Cincinnati Health Department
School and Adolescent Health Program
Consent Form for 2025-2026 Seasonal Influenza Vaccine

COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME: _____

STUDENT NAME (Last)	(First)			(M.I.)	GRADE/HR
DATE OF BIRTH	AGE	GENDER M / F	RACE	PHONE NUMBER	
STREET ADDRESS	CITY		STATE		ZIP

INSURANCE STATUS:
□ Medicaid □ CareSource □ United Healthcare Community Plan □ Molina □ Paramount □ Buckeye
□ No Insurance □ Private Insurance _____ Insurance Billing#_____
Medical Card Billing Number# _____ Child's SS#_____
*No student will be denied the flu vaccine due to inability to pay or lack of insurance

B. In order to determine if your child needs a booster dose, please answer this question:

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010? □ Yes □ No □ Unsure

C. Please answer all of the following questions:

	YES	NO
1. Is the student sick today with fever or respiratory illness?	□	□
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	□	□
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	□	□
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	□	□

D. Please answer all of the following questions:

	YES	NO
1. Does the student have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	□	□
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health care provider told you that he or she had wheezing or asthma?	□	□
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?	□	□
4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	□	□
5. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	□	□
6. Is the student receiving anti-viral medications?	□	□
7. Is the person pregnant or could become pregnant in the next month?	□	□
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or Flu Mist? If yes, give type and date. Recent Vaccinations: _____ Date received: _____	□	□

E. Consent

CONSENT FOR VACCINATION:
I understand I will receive the **Flu Vaccine Information Statement** and be offered the **Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.**

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____
Print Name of Parent Legal/Guardian_____
Parent Cell Phone Number: _____

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY):

Vaccine	Date Dose Administered	Route	Lot Number	Name and Title of Vaccine Administrator
2024 Seasonal Flu	/ /2024	L Arm R Arm □ IM		
Booster Dose	/ /2023	L Arm R Arm □ IM		