



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.



Asthma Questionnaire

To be completed by parent

Columbus City Schools
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 _____

*The 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 asthma 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 asthma and emergency plans.

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? ☐ allow to rest and cool down ☐ rescue inhaler
☐ nebulizer ☐ other: _____

Daily medication name:	Dosage:	When taken:
"As needed" or rescue medications:	Dosage:	How often:
☐ Albuterol MDI	90 mcg 2 puffs	
☐ Other		

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

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

Date _____

Parent/Guardian Signature _____

RETURN TO SCHOOL NURSE IMMEDIATELY



AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____

Student Full Name:		Birth Date:	
School Name:		School Phone:	
Requested by: Name, Title		School Fax:	

☐ Fax Info to School ☐ Email Info to: _____

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.

I understand the requested information below will be used by the Columbus City School staff for educational and health care planning and service delivery at school.

Provider Name and Address	Provider Fax #	Provider Phone #

Dates Range of Records Requested: From Date: _____ To Date: _____

☐ Medical Info/Records: **specified below** ☐ Psychological Information/Records ☐ Immunization Records
☐ TB Test Results/Records ☐ Speech and/or Hearing Evaluation ☐ School Health Records

Specific Information Requested for educational and health care planning and service delivery at school :

--

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

PR-10 PARENTAL CONSENT TO SHARE HEALTH INFORMATION FOR THE OHIO MEDICAID SCHOOL PROGRAM

CHILD'S INFORMATION

CHILD'S NAME _____

DATE OF BIRTH ____/____/____ DISTRICT NAME _____

Ohio school districts have the opportunity to receive federal Medicaid dollars through a program called the Ohio Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for therapy services such as Speech, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling, and Social Work services. In the process of billing Medicaid for these services, billing information must be shared with the Ohio Department of Medicaid. For Medicaid billing purposes, schools must obtain a one-time signed Parental Consent to Share Health Information for the Ohio School Medicaid Program. After this one-time written consent, you will receive an annual notice of this consent.

Schools request this consent for all students who receive therapy services, even students who may not be currently enrolled in Medicaid. Some health information shared is specific to your student, while other information is related to all students within the entire school district. Schools can use this health information to help reduce costs for services that the district must deliver pursuant to the Individuals with Disabilities Education Act (IDEA). This student specific health information is protected and will be accessed only by people authorized to do so by the school's Medicaid contract.

Your consent is voluntary. You have the right to withdraw your consent at any time (34 CFR Part 99 and Part 300.) You are not required to enroll in Medicaid. If your school does bill Medicaid, you will not be required to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increased premiums or the discontinuation of benefits, or result in you paying for services.

Regardless of whether you grant consent, refuse consent, or revoke your consent, your child will still be provided with an evaluation and/or the services as identified by the school district at no cost to you.

____ I understand and agree to give permission to share my child's *specific* health information in order for the school to access Medicaid.

____ I do not give permission to share my child's *specific* health information in order for the school to access Medicaid.

Parent (printed) Name _____

Parent Signature _____

Date ____/____/____

Please contact **Healthcare Billing Services, Inc.** at **(740) 639-4218** with questions or if you feel you have incurred a personal cost for these services.



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.**
- **Medications cannot be at school without the form and signatures of both doctor and parents. Medications cannot be held until the medication authorization form arrives.**
- **A new Medication Authorization Form is required each school year AND when there is a change in medication or dose.**
- **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 medication cannot be expired.**
 - 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.
- **Medication must be brought to school by the parent or guardian. Bus drivers cannot be responsible for medications on the bus.**
- **School personnel cannot give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization Form is required.**
 - 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, eye drops, ointments.)
 - Over the counter medications must be in the original container and not expired.
 - A label must be attached to the medication which includes: the student's name, name of medication, dosage, strength, route, time of administration and expiration date. Label must match the Medication Authorization Form.
- **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 student attendance or it will be discarded.



Asthma Medication Authorization

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

Columbus City Schools
Health, Family and Community Services
Columbus Ohio 43215

Student Name _____ Date of Birth _____ School Year _____

Home Address _____ School _____ HR/Grade _____

If multiple medications are needed at school, please contact your school nurse for the appropriate forms

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 _____

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 _____

For asthma inhaler: The student has demonstrated the proper use of the medication?

☐ yes ☐ no
☐ yes ☐ no

The student is capable and may carry and self-administer medication per ORC 3317.716 and 3313.718.

Healthcare Provider Signature _____ Date _____

Provider Name _____

Practice Address _____

Phone _____ Fax _____

Please fill contact information to left or stamp here

Parent to Complete:

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 _____ Phone Number _____ Date _____

PLEASE return this form to _____, School Nurse

Email: _____@columbus.k12.oh.us Phone _____ Fax 614-365-_____



Medication Authorization

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

Columbus City Schools
Health, Family and Community Services
Columbus Ohio 43215

Student Name _____ Date of Birth _____ School Year _____

Home Address _____ School _____ HR/Grade _____

If multiple medications are needed at school, please contact your school nurse for the appropriate forms

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 _____ or ☐ 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:

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 _____ Phone Number _____ Date _____

PLEASE return this form to _____, School Nurse

Email: _____@columbus.k12.oh.us Phone _____ Fax 614-365-_____