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.

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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

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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

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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.

Columbus City Schools
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.**
- **Medications cannot be at school without the form and signatures of both doctor and parents. Medications cannot be held until the mediation 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.

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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-**_____

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Epinephrine Auto-Injector 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:

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:

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 _____ **Phone Number** _____ **Date**_____

PLEASE return this form to _____, School Nurse

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

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COLUMBUS CITY SCHOOLS

Special Diet Order

Health, Family and Community Services
Columbus Ohio 43215

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

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