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

Health forms for students with

Seizures

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

What is in this packet?

1) Seizure Questionnaire to describe student's seizure disorder

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

3) Guidelines for Medicines at School – parent reference

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

Questions - Please call your school nurse.

Seizure Disorder 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 _____ Phone_____
Parent/Guardian _____ Phone_____
Emergency Contact_____ Relationship_____ Phone_____
Healthcare Provider_____ Phone_____ Fax_____

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

Seizure Information

Seizure Type	Length	Frequency	Description

What happens during the seizure?

How long has your child had seizures? | What triggers the seizure?

Are there any warning or behavior changes before the seizure? ☐ **yes** ☐ **no** If yes, please explain:

How long does the seizure last? | What time of day do the seizures usually happen?

How often do they have a seizure? | Date of their last seizure?

How do other illnesses affect your child's seizure control?

Medication	Dose & Time	Medication	Dose & Time

Student has a Vagus Nerve Stimulator (VMS)? ☐ **yes** ☐ **no** If yes, describe use:

Special considerations & safety precautions for school activities:
☐ General health ☐ Gym/ sports (physical activity) ☐ Physical functioning ☐ Learning ☐ Field trips
☐ Recess ☐ Bus transportation ☐ Mood / coping ☐ Behavior ☐ Other
Explain:

What happens when your child misses a dose of seizure medication?

Are there any other recurring or chronic health problems?

Any other information that would be helpful for the teacher or nurse to know?

I authorize Columbus City Schools to communicate with my child's teachers, principal/administration, school nurse and other school personnel about the seizures.

Parent's signature: **Date:**

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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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.

04/2024

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