



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) Parent Letter – information and supplies list
- 2) Seizure Questionnaire - to describe student's seizure disorder
- 3) Release of Information - allows the doctor to talk to the school nurse if there are any questions
- 4) Guidelines for Medicines at School – parent reference
- 5) Medication Authorization - must be signed by parent and doctor and brought to school with any medication
- 6) Request for Specialized Health Care Services – completed by doctor if VNS, helmet or other specialized care needed at school

Questions - Please call your school nurse.



Seizure Disorders – Parent Letter

Dear Parent/Guardian of: _____

Date: _____

Columbus City Schools provides nursing services and works closely with the student’s parents/guardians and Healthcare Providers to promote the student’s ability to learn. Our goals are to:

- Assist students in learning how to take care of their health.
- Ensure a safe school environment.
- Promote good control of a student’s health condition so they are ready to learn.

If your student with seizures requires medication, equipment or devices to be given or used at school, the parent and healthcare provider must complete the appropriate forms listed below. **To assist your child at school all seizure related medication and equipment forms must be renewed and updated every school year.**

Parent/guardian, please note:

1. Only a nurse can give Diastat. If your student’s school does not have a full-time school nurse, the parent can request a medical transfer to a school that has a full-time nurse.
2. If the school nurse is not in the building and the student has a seizure: CCS staff will FOLLOW EAP TO determine if emergency care is needed and will call Emergency Medical Services (EMS) and the parent/guardian. EMS will determine if the student needs hospital care, can remain in school or the parent/guardian is to take the student home.

Parent/Guardian: Please return the completed forms below to the school nurse prior to starting school:

- **Seizure Disorder Questionnaire** – Parent completes
- **Release of Information** - Parent completes
- **Medication Authorization Form - one form for each medication** - Healthcare Provider completes; Parent signs
- **IF needed - Specialized Care Order Form** – can include helmet and Vagus Nerve Stimulator Orders

Parents: bring all needed supplies and the completed forms listed above to the school nurse; these are needed for school personnel to follow medical orders and properly care for your student. Below are items your student **may** need at school:

- | | |
|--|---|
| <input type="checkbox"/> Diastat Syringe Kit | <input type="checkbox"/> Helmet |
| <input type="checkbox"/> Midazolam Kit | <input type="checkbox"/> Vagus Nerve Stimulator |
| <input type="checkbox"/> Any medication prescribed | <input type="checkbox"/> Other: _____ |

Please contact the school nurse with any questions or concerns. Thank you for your help in obtaining the necessary orders.

Your student’s School Nurse is: _____ Phone Number: _____

Days at school: _____



Seizure Disorder 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 _____

Complete this form if the child has been diagnosed with seizures. 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.

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 seizures and emergency plans.

Seizure Information			
Seizure Type	Length	Frequency	Describe seizure:
How long has your child had seizures?		What triggers the seizure?	
Are there any warnings or behavior changes before the seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
Do seizures happen at a certain time of the day or random?		Date of their last seizure?	
How do other illnesses affect your child's seizure control?			
Are seizure medications needed AT SCHOOL? <input type="checkbox"/> Yes-List <input type="checkbox"/> No		Dosage	When taken?
<i>IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.</i>			
Seizure medication AT HOME: <input type="checkbox"/> Yes-List <input type="checkbox"/> No		Dosage	When taken?
Student has a Vagus Nerve Stimulator (VNS)? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, describe use:			
Special considerations & safety precautions for school activities: <input type="checkbox"/> Wears a helmet			
<input type="checkbox"/> General health	<input type="checkbox"/> Gym/ sports (physical activity)	<input type="checkbox"/> Physical functioning	<input type="checkbox"/> Learning
<input type="checkbox"/> Recess	<input type="checkbox"/> Bus transportation	<input type="checkbox"/> Mood / coping	<input type="checkbox"/> Behavior
			<input type="checkbox"/> Field trips
			<input type="checkbox"/> Other
Explain:			
Are there any other recurring or chronic health problems?			
Any other information that would be helpful for the teacher or nurse to know?			

Parent/Guardian Signature _____ Date _____

RETURN TO SCHOOL NURSE IMMEDIATELY



Columbus City Schools

AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____

DATE OF BIRTH: _____

STUDENT #: _____

I hereby give consent for the exchange of the information as checked below concerning the above-named child between the party indicated and Columbus City Schools.

Obtain Information From: _____

Release Information To: _____

- Medical Information/Records
- TB Test Results/Records
- Immunization Records
- Achievement and Aptitude Test Scores
- Psychological Information/Records
- Grades and Attendance
- Speech and/or Hearing Evaluation
- Individual Education Plan (IEP), if in Special Education
- Other Information, as specified: _____

This information to be used for: _____

Parent/Guardian Signature

Date

Electronic signature permitted.



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 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.

- **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.***



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 _____ 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 _____



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:

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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 _____



Request for Specialized Health Care Services

Health, Family and Community Services
Columbus Ohio 43215

To the Healthcare Provider: The Columbus Board of Education urges you to schedule health care procedures outside of school hours. Treatments administered three times a day or less, except those that are required at certain times, should be completed at home.

Please provide specific orders for the following student:

Student Name _____ Date of Birth _____ School Year _____

School _____ HR/Grade _____ **Early Childhood Only:** **Morning Session**
 Afternoon Session
 Full Day Session

Student need: _____

Healthcare Provider to Complete:

- Diagnosis:**
- Procedure:**
- Frequency/Time/schedule:**
- Beginning date:** _____
- Expiration date:** _____

Healthcare Provider Signature _____ Date _____

Provider Name _____

Practice Address _____

Phone _____ Fax _____

Please fill contact information to left or stamp here

PLEASE return this form to _____
Licensed School Nurse Phone Fax

I, the undersigned, who is the parent/guardian of the above named student, request that the specialized health care service prescribed above will be provided for my child. I understand the school to appoint a qualified designated person(s) to perform the above prescribed treatment. I agree to notify school personnel of any change in my child's treatment regimen or the authorizing health care provider.

Parent/Guardian Signature _____ Date _____