BISHOP WATTERSON HIGH SCHOOL
Exemplary Catholic Education,
Rooted in Faith, Committed to Excellence

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) 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.

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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 student 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 your student has a seizure: CCS staff will follow the Emergency Action Plan 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. Checked below are the items your student **may need at school:**

- Δ Diastat Syringe Kit
- Δ Midazolam Kit
- Δ Any medication prescribed
- Δ Helmet
- Δ Vagus Nerve Stimulator
- Δ 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: _____

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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? ☐ **Yes** ☐ **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? ☐ **Yes-List** ☐ **No**	**Dosage**	**When taken?**
IF medication is needed at school, parent must complete the Medication Authorization Form and bring the medication to school.		

Seizure medication AT HOME: ☐ **Yes-List** ☐ **No**	**Dosage**	**When taken?**

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

Special considerations & safety precautions for school activities: ☐ Wears a helmet

☐ General health ☐ Gym/ sports (physical activity) ☐ Physical functioning ☐ Learning ☐ Field trips
☐ Recess ☐ Bus transportation ☐ Mood / coping ☐ Behavior ☐ 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

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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 _____

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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.**

- **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.***

03/07/19

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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_____Strength/Concentration_____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**_____

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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 _____