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This packet contains medical forms for students *returning* to Columbus Torah Academy

Here is a list of what is in this packet:

1. Detailed **summary** of needed information and forms.
2. **Release of Information**: parent to complete this page – this allows the nurse to speak with the students' doctor.
3. **Health History**: parent to complete this page – this is to notify the nurse of changes in the child's health.
4. **Physical Exam**: completed by the doctor at the yearly well check - it is excellent information for the nurse but not required.
5. **Oral Assessment**: completed by the dentist - it is excellent information for the nurse but not required.
6. **Over the Counter medicine form**: a doctor and the parent must complete this page for staff to give a medicine that you can buy without a doctor's prescription. It is not required.

An updated immunization record is required for all students entering 7th AND 12th grade. It must be submitted by the 14th day of school!

7th: The child must have a TDaP and a meningitis vaccine.
12th: The child must have a second meningitis vaccine.

For school staff to give a student medicine a doctor has prescribed the doctor and a parent must complete a medication authorization. These forms are also on the school website. You may also contact the school for these forms.

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Health Packet for students *returning* to Columbus Torah Academy

Forms:

1. Parent - complete a **Health History Form** for your child each year, especially if there are changes to any medical conditions. Please share any information that will help me to care for your child during the school day. Any private health information may be noted on this form – BUT, please write that the information is to be kept confidential on the form.
2. While not required, it is also recommended to have a current **Physician Examination Form** and Oral Assessment on file. When you visit the doctor or dentist for your child's well check, please give the nurse a copy of the visit summary.

Students entering 7th grade and 12th grade need to receive immunizations!

Ohio law (ORC 3313.671) requires immunizations before the start of school. Please send the updated immunization form to the school nurse. *Your child will not be permitted to remain in school for more than 14 days without proof of immunizations.* Immunizations needed:

7th grade: need to have the Tdap vaccine AND the meningitis vaccine
12th grade: need a second dose of the meningitis vaccine

Medication administration during the school day:
Parents may come to school to administer medications to their child as needed.
Medications ordered three times a day or less, unless a time is specified, may not need to be taken at school. The medication should be given before school, after school, and at bedtime. All medicine is stored in the nurse's office. ALL medicine must be brought to office school by an adult. The only medicine students may carry with them are asthma inhalers and epinephrine for severe allergies.

Over the Counter Medicine – 1 form needed:
As a courtesy, the school stocks select OTC medicine for students. A doctor and a parent must complete the **Over the Counter Medicine Form** in this packet for staff to give these. This is optional.
ALL other OTC medicines need a medication authorization completed by the doctor and a parent, see below.

Prescription Medicine – 2 forms needed:

1. The **Release of Information** is completed by a parent. This form needs to be filled out to allow the school to communicate with the doctor if we are giving medication at school.
2. The **Medication Authorization** Is completed by the parent and the doctor. Medicine must be in the original container form the pharmacy.

Contact the school office if you need forms for medications. These forms are on the school website.

Please contact the school nurse if you have concerns about your child's health at school. Chris Morford, BSN, RN, Licensed School Nurse

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AUTHORIZATION FOR RELEASE OF INFORMATION

CHILD'S NAME: _____

DATE OF BIRTH: _____

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

Obtain Information From:

Release Information To: Columbus Torah Academy School Nurse
Chris Morford, BSN, RN, LSN
181 Noe Bixby RD
Columbus, OH 43213
(614) 864-0299 ext. 211
cmorford@torahacademy.org

- 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 continuity of care.

Parent/Guardian Signature: _____

Date: _____

Electronic signature permitted

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date
		/ /

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments
_____
_____
_____

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No

Child has possible problem with _____

Lead Poisoning

☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL
☐ Date _____ Type ☐ C ☐ V Results_____ µg/dL

Tuberculin Test

Date_____ Type _____ Results_____

Health History (Serious or chronic illnesses/injuries/surgeries)

_____

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

_____

_____

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

_____

_____

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

_____

_____

HealthCare Provider's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ( )
Address		Date / /
City	State	ZIP

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Authorization for dispensing of over the counter medications and treatments

The Columbus Torah Academy has the following medications and treatments available for dispensing to students by the nurse on an as needed basis. In order for the student to receive these written permission from both the parent as well as a healthcare provider is required. Check those medications and treatments that your child has permission to receive.

Complete one form for each child, please.

Student's Name: _____ DOB: _____ Grade: ____

___ Ibuprofen (weight appropriate dosage) every 6 hours, by mouth, for mild to moderate pain

___ Acetaminophen (weight appropriate dosage) every 4 hours, by mouth, for mild to moderate pain

___ Tums for indigestion, by mouth

___ Caladryl lotion for minor skin irritation, topically

___ Aquaphor for minor cuts and scrapes, for chapped lips, topically

Generic equivalents may be substituted.

Information the nurse should be aware of prior to medication administration: _____

Medication Allergies: _____

I hereby request and give permission to the school approved personnel to administer the above medication(s) to my child. I further acknowledge by signing this form that the school or its personnel are under no obligation to render assistance in the administering of medication. I release and agree to hold the Columbus Torah Academy Board, its officials, and its employees and staff harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parent Signature: _____ Date: _____

***** ***Healthcare Provider Signature is REQUIRED*** *****

Healthcare Provider Signature: _____
Date: _____

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