Inspire. Learn. Achieve.

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

*All students new to CTA must submit an updated **immunization record** from the doctor. This must be submitted by the 14th day of school!*

Here is a list of what is in this packet:

1. Detailed **summary** of medical information and forms.
2. **Physical Exam**: completed by the doctor at the yearly well check – it is required for all NEW students. The form may be dated within the past 13 months – this is due to insurance rules.
3. **Release of Information**: parent to complete this page – this allows the nurse to speak with the students' doctor.
4. **Health History**: parent to complete this page – this gives the nurse an accurate history of your child's health.
5. **Oral Assessment**: completed by the dentist - it is excellent information for the nurse but not required.
6. **Over the Counter** (OTC) **medicine form**: 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. OTC medication cannot be given without a completed form on file. Form must be dated AFTER 6/11/2023.

Please contact the school nurse if you have concerns about your child's health at school at nurse@torahacademy.org

Inspire. Learn. Achieve.

Medical forms for students *NEW* to Columbus Torah Academy

Dear Parent/Guardian,

My name is Sally French, I am the school nurse at Columbus Torah Academy, welcome. If you have health concerns regarding your child, please feel free to contact me throughout the school year. The purpose of this letter is to inform you of the medical paperwork required for your child to attend school.

The **5 forms** are described below. Two forms are from the doctor; 2 forms are filled out by a parent; and 1 form is from the dentist.

1. Please provide an updated copy of the student's **immunization record**. The full date (month/day/year) of each required vaccination is to be listed on the form. According to Ohio law (ORC 3313.671) your child will not be permitted to remain in school for more than 14 days without proof of immunization. *You can get the immunization record from your doctor's office.*
2. A copy of the child's most recent **physical examination** is needed for every student new to CTA. The Ohio Department of Education recommends that a physical examination shall occur within 13 months before the first day of school. The date of the exam must be documented on the form with the Physician's signature. Only hard-copy forms can be accepted. *This form is due upon admission*. Ask your doctor to complete *the form is in this packet OR ask for a visit summary from your last well check.*
3. The **Release of Information** is completed by a parent. This form needs to be filled out to allow the school nurse to communicate with the doctor.
4. A parent or guardian may complete the **health history** form. *It is in this packet.* Please share any information that will help me to care for your child during the school day. Including any allergies and any medications taken at home. Private health information may be noted on this form – BUT, please write that the information is to be kept confidential on the form.
5. A dental exam or **Oral Assessment**, while not required, is strongly suggested. The form is *in this packet.* Note: this form can be completed by the dentist with information from a recent exam or it can be completed at the next visit, if it is soon.

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 from the pharmacy.

Over the Counter (OTC) 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. OTC medication cannot be given without a completed form on file. *ALL other OTC medicines need a medication authorization completed by the doctor and a parent, see below.*

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.

Contact the school office if you need forms for medication. These forms are also available on the school website.

Ohio Department of Health • School and Adolescent Health

Physical Examination

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

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

Inspire. Learn. Achieve.

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
181 Noe Bixby Rd
Columbus, OH 43213
(614) 864-0299 ext. 211
nurse@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

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

Inspire. Learn. Achieve.

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 this 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: _____

181 Noe Bixby Road • Columbus Ohio 43213 • 614.864.0299 • Fax 614.864.2119
Founded in 1958