Columbus Academy

Dear 3-Year-Old and PreK Families,

Enclosed you will find health forms and health information for the new school year. Please take time to complete the forms and return them no later than the first day of school. These forms are mandatory for your child's admission to the Columbus Academy 3YO and PreK programs.

1) Emergency Medical Authorization Form
This form is used whenever a student has a health concern at school. **State law requires that each student have this form on file yearly**. It is important that you include telephone numbers to contact you in an emergency. Also, please include names and telephone numbers of individuals who can be contacted if you are unavailable. Consent for medical treatment covers only an emergency as determined by emergency medical services. It does not mean that you are consenting for routine care.

2) Health History Form
The Physical exam section must be signed and dated by your child's pediatrician. The date of the physical exam is required by state law and is only good for one year. If your child's yearly exam falls in the middle of the school year, you will need to provide that information to the school nurse. Some students have special health needs that require accommodations in school or a plan in the event of an emergency. If your child has a known health condition, please contact the school nurse to discuss a plan in the case of an emergency. Medical information will be kept confidential at your request. **All students in Ohio are required to have up-to-date immunizations documented to attend school.**

3) Authorization for Over-the-Counter Medications Form
This form allows the school nurses to administer non-prescription medications at school. Any other nonprescription medications not listed may be sent in to the school nurse in the original container with written instructions.

Prescription medications may also be administered on a daily or temporary basis at school. All prescription medications, including inhalers, must be accompanied by a signed authorization from the health care provider. Medications must be in the original container with a clearly marked label. Please contact the school nurse for the appropriate forms.

Screening for vision and hearing will be done for PreK students as mandated by the state. If any problems are identified, parents will be notified. Students who wear corrective lenses should have them at school.

Illness in School. If your child is sick in the morning or has a fever, please do not send him/her to school. Also, children should be fever-free for 24 hours before returning to school. Please notify the school nurse if your child becomes ill with a communicable disease. **Student absences should be reported to the Lower School Office at 614-509-2258.**

Please contact us at any time to discuss any health care issues or concerns.

Beckie Hoagland, RN, BRN, LSN
School Nurse
HoaglandB@columbusacademy.org
614-509-2234

Janet Fireman, RN, BSN, LSN
School Nurse
FiremanJ@columbusacademy.org
614-509-2234

Please return completed form to:

Columbus Academy
Nurses
4300 Cherry Bottom Rd
Gahanna OH 43230

Columbus Academy
Health History for 3YO Program and Pre-Kindergarten
Confidential

Child's Name _____Date _____
Birth Date_____ Sex: _____male _____ female
Name of Parent/Guardian_____
Name of Parent/Guardian_____

Immunization Record-please list the month/day/year or attach separate sheet
DPT _____ _____ _____ _____ _____
Polio _____ _____ _____ _____
MMR _____ _____
Hib _____ _____ _____ _____
HEP B _____ _____ _____
Varivax _____

Physical Exam (to be completed by child's physician)
HT_____ WT_____
Please list any abnormal findings: _____

Is there any reason this student cannot participate in a full program of school activities?
Yes or No If yes, please explain. _____
The above child has been examined and has been found to be free of infections or contagious disease.

Physician's Name (please print)_____
Physician Signature_____ Date of exam_____
Address_____Telephone_____
(Students in 3YO program and pre-kindergarten must have physical exam documented every 12 months)

Below is a list of medical questions that are asked for the purpose of assisting your child with any educational needs due to a health condition. This information is kept confidential in the nurses' office. If you would prefer to discuss your child's medical history please notify Beckie Hoagland RN BSN, School Nurse at 509-2234.

Perinatal History
Did the mother have any complications during pregnancy or birth? ____yes ____no
If yes, explain: _____
How old was the mother when the child was born? _____
Was the infant born: ____full term ____early ____late Birth weight_____
Did the infant have any problems while in the nursery? ____yes ____no
If yes, explain: _____

Developmental History
Please give the approximate age at which this child: walked alone_____
was toilet trained_____ spoke in sentences_____ dressed self_____
How does this child's development compare to other children, such as brothers/sisters or playmates? _____about the same _____slower _____faster
This child is usually: _____very active _____normally active _____ rather inactive

Family History
Please list the child's brothers and sisters
1. _____ birth year_____ sex_____
2. _____ birth year_____ sex_____
3. _____ birth year_____ sex_____
4. _____ birth year_____ sex_____

Health Conditions
Please check any that this child has:

___Abnormal Spinal curvature
___Allergies
___Anemia
___Asthma
___Bedwetting
___Behavior problems
___Birth or congenital malformation
___Bleeding disorder
___Cancer
___Chicken pox
___Chronic diarrhea or constipation
___Cystic Fibrosis
___Diabetes
___Eating disorder, obesity
___ Eczema
___ Emotional problems
___ Frequent ear infections
___ Frequent headaches
___ Frequent sore throats
___ Hearing loss
___ Heart condition
___ Kidney disease
___ Nervous twitches or tics
___ Seizures
___ Stool soiling
___ Vision loss
___ Wetting during day
Other_____

Please explain the above: _____
_____
Please list any severe injuries or other illnesses: _____
_____

Additional Information
What medications are given daily? _____
What medications will need to be given at school? _____
(Required forms available in nurses' office)
Does your child carry an inhaler? _____
(Required forms available in nurses' office)

The space below is provided for you to list any additional information concerning your child's health, medical conditions, or home life of which the school staff should be aware.
_____
_____
_____

_____
Parent/Guardian Signature Date

Parent's Authorization for Dispensing Over-The-Counter Medications

Student's Name_____

Columbus Academy has the following medications available for dispensing to students by the school nurse as needed. In order for the student to receive these, a parent must provide written consent.

_____Acetaminophen (Tylenol)-liquid, chewable, and tablet

_____Ibuprofen (Advil, Motrin)-liquid, chewable, and tablet

_____Tums tablets (antacid)

_____Maalox (antacid)

_____Benadryl (antihistamine)-liquid and tablet

_____Claritin (antihistamine)-liquid

_____Neosporin (triple antibiotic ointment)

_____Caladryl lotion (topical analgesic)

_____Calamine lotion (skin protectant)

_____1% Hydrocortisone cream

_____Benadryl Spray (topical anesthetic)

_____Sudafed (decongestant)-age 6 and over

_____Mucinex (decongestant)-liquid

_____Cough drops

Additional information or directions for the use of the above medications:

_____

_____

I give permission for my child to receive the medications checked above as administered by the school nurse or her designate.

Parent Signature _____ Date_____

The Columbus Academy Emergency Medical Authorization/Travel Authorization/Release

Student_____ Grade_____ Birth Date __/__ / __

Address_____Phone_____

As the parent/guardian of the above named student, I hereby acknowledge my understanding that off campus travel, including in some cases, overnight stays, is an important part of the educational and athletic programs of the school, and that such travel for educational or athletic programs or events may be by one or more contract buses, school vans or by private vehicle driven by a school employee or by a parent volunteer. The school shall notify me before any such off campus travel is undertaken and shall provide me with details of such travel, including the purpose of such travel, a schedule of events including times of departure, arrival and return, and mode of travel. I hereby authorize my child to participate in such trips during the current school year, and I release and forever discharge The Columbus Academy and its trustees, employees, agents, their heirs, successors and assigns, either jointly or severally, from any and all claims, damages, obligations, causes of actions or suits, resulting from bodily injury to my child or damage to or loss of my child's property arising from participation in such travel.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Signature Date

Residential Parents/Guardians:

Name_____ Daytime phone_____ Cell phone or pager_____

Name_____ Daytime phone_____ Cell phone or pager_____

Other Persons with authorization to consent for care:

Name_____ Daytime phone_____ Cell phone or pager_____

Address_____Relationship_____

Name_____ Daytime phone_____ Cell phone or pager_____

Address_____Relationship_____

Insurance Information

Insurance Co._____ Phone_____ Policy Holder_____ Policy/Group #_____

You must complete either PART 1 or PART 2 below. Purpose: To enable parents and/or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Part 1: To Grant Consent: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the following health care providers, or if the designated preferred practitioner is not available, by another licenses physician or dentist; and (2) the transfer of the student to any hospital reasonably accessible.

Physician_____ Phone_____ Medical Specialist_____ Phone_____

Dentist _____ Phone_____ Medical Specialist_____ Phone_____

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken and any physical impairments or chronic conditions to which a physician should be alerted include:

_____

Parent/Guardian signature _____ Date_____

Part 2: Refusal to consent: I do not give my consent for emergency treatment of my child. In the event of illness injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Parent/Guardian signature _____ Date_____