Division of School and Adolescent Health
2136 West Eighth Street
Cincinnati, Ohio 45204
(513) 357-2808 phone
(513) 357-2811 fax

August 2016

Dear Parent or Guardian,

Please fill out all of the enclosed health forms and return the forms to your child's school.

The **Emergency Medical Authorization** form is needed in case of an emergency at school. It gives school officials permission to get emergency treatment for children who become ill or injured while at school, when parents or guardians cannot be reached.

If your child needs **prescription medication** during the school day, your Doctor must fill out the **CPS Administration of Medication Form**, which is available from your child's school office, and you must sign it.

The **Authorization for Administration of Over-the-Counter Medications at School** form gives the nurse, school health assistant, or principal's designee permission to give medication to your child for comfort measures.

The **Health History Update** form gives school personnel pertinent health information regarding your child and is required by Ohio law. It must be updated every school year.

The **Consent Form for 2016-17 Seasonal Influenza Vaccine** is needed for your child to receive the flu vaccine at school this year. It gives the Cincinnati Health Department permission to administer the vaccine. The flu vaccine will be given between September and December 2016.

A **School-Based Health Center Enrollment Packet** also may be included. If you want your child to receive the services listed, complete and return the packet to your child's school health office.

Your school nurse and the Cincinnati Health Department collaborate with the pediatric providers at Cincinnati Children's Hospital Medical Center to assure the best coordinated care for your child. The school nurses can access electronic health records from Cincinnati Children's. They do this in order to verify medication orders, confirm follow-up appointments, reference discharge plans, etc.

For children with chronic conditions (such as asthma, diabetes, seizure disorder, sickle cell disease), additional paperwork is needed. This can be obtained through the school health office at your child's school.

Thank you in advance for your attention to these important documents and for partnering with me in guarding your child's wellness!

Respectfully,

Marilyn Crumpton, MD, MPH
Medical Director for School & Adolescent Health
Cincinnati Health Department

Cincinnati Public Schools

Emergency Medical Authorization Form

Please fill out this form and return it to your child's school.

Student's Name: _____ ID #: _____ Homeroom: _____ Birth Date: _____

School: _____ Grade: _____ Year: _____

Student's Address: _____ Apt.: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Purpose — To enable parents and 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.

Residential Parent or Guardian

Mother's Name: _____ Daytime Phone: (____) _____

Father's Name: _____ Daytime Phone: (____) _____

Other's Name: _____ Daytime Phone: (____) _____

Name of Relative or Child-care Provider: _____

Relationship: _____ Daytime Phone: (____) _____

Address: _____ Zip: _____

PART I or II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical-care providers and local hospital to be called:

Physician: _____ Phone: (____) _____

Dentist: _____ Phone: (____) _____

Medical Specialist: _____ Phone: (____) _____

Local Hospital: _____ Emergency Room Phone: (____) _____

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 above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Zip: _____

PART II: REFUSAL TO GRANT CONSENT I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school to take the following action:

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____ Zip: _____

Cincinnati Public Schools

Emergency Medical Authorization Card

Please fill out this form and return it to your child's school.

Student's Name: _____ ID #:_____ Homeroom: _____Birth Date: _____

Cincinnati Public Schools
EMERGENCY MEDICAL AUTHORIZATION FORM

School: _____ Grade: _____ Year: _____

Student's Address: _____ Apt.:_____ Phone: (___)_____

City: _____ State: _____ Zip: _____

Purpose – To enable parents and 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.

Residential Parent or Guardian

Mother's Name: _____ Daytime Phone: (___)_____

Father's Name: _____ Daytime Phone: (___)_____

Other's Name: _____ Daytime Phone: (___)_____

Name of Relative or Child-care Provider: _____

Relationship: _____ Daytime Phone: (___)_____

Address: _____ Zip: _____

PART I or II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical-care providers and local hospital to be called:

Physician: _____ Phone: (___)_____

Dentist: _____ Phone: (___)_____

Medical Specialist: _____ Phone: (___)_____

Local Hospital: _____ Emergency Room Phone: (___)_____

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 above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

Date: _____ **Signature of Parent/Guardian:** _____

Address: _____ Zip: _____

PART II: REFUSAL TO GRANT CONSENT: I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school to take the following action:

_____

_____

Date: _____ **Signature of Parent/Guardian:** _____

Address: _____ Zip: _____

Welcome to the School-Based Health Center
Cincinnati Health Department
Enrollment Packet
for students at NON-SBHC schools

PLEASE COMPLETE AND SIGN ALL PAGES.

Patient's Name: _____ DOB: _____ Sex: ___M ___F ___Transgender

Patient's Social Security # (if known) _____ Medicaid/Insurance Provider: _____

Medicaid/ Insurance #: _____

EYE CLINIC SERVICES:

__ YES, I consent for my child to receive **EYE CLINIC SERVICES** at the OneSight Vision Center at Oyler School, which may include comprehensive eye examinations including dilation, vision therapy, and the fitting and dispensing of vision correction. My child may be **TRANSPORTED/ACCOMPANIED** to and from medical, dental or eye center services by a school designee. I, the parent or guardian of above named student release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and the Cincinnati Public School District, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

__ NO, I do not wish for my child to receive **EYE CLINIC SERVICES** at the OneSight School-Based Eye Center.

DENTAL HEALTH CARE SERVICES:

__ YES, I consent for my child to receive **DENTAL SERVICES** at a Cincinnati Health Department (CHD) Clinic or school-based/mobile clinic including preventive care, dental examinations, x-rays, sealants, fillings, local anesthesia, tooth removal, and root canals if necessary. Sealants and other preventive procedures will be provided at school. My child may be **TRANSPORTED/ACCOMPANIED** to and from medical, dental or eye center services by a school designee. I, the parent or guardian of above named student release the City of Cincinnati, its City Council members, employees, and authorized agents and representatives and the Cincinnati Public School District, its board members, administrators, employees and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my student to and from health services.

__ NO, I do not wish for my child to receive **DENTAL SERVICES.**

PRIMARY HEALTH CARE SERVICES: (Available at following schools and sites: Aiken High, Academy of World Languages (AWL), Children's Home of Cincinnati, Mt. Airy, Oyler, Parker, Riverview East, Roberts, Roll Hill, Taylor, Taft High, Western Hills /Dater high campus, and Withrow High)

__ YES, I consent for my child to receive **MEDICAL CARE** including routine well child care **(*see last page)** (includes work, day care, and sports physicals), appropriate immunizations, fluoride varnish and treatment for illness or injury including over-the-counter medications unless emergency services are needed. (***Note:** Well child care includes vision and hearing screening, urine and blood tests, immunizations as needed, and an external genital exam when appropriate.)

__ NO, I do not wish for my child to receive **MEDICAL CARE** at the School-Based Health Center (SBHC).
Please note that in Ohio minors may access confidential service for sexually transmitted infections and family planning, including provision of contraception such as condoms or birth control pills without parental consent.

By signing this consent, I agree to the terms and conditions regarding the **PAYMENT FOR SERVICES** and **SHARING OF HEALTH INFORMATION** as explained in the accompanying **Program Description** form. I also have received and agree with the **Patient Consent for Use and Disclosure of Protected Health Information** as explained in the **Program Description** form. I have received the **Notice of Privacy Practices,** which is attached separately.

_____ _____

Parent/Guardian Signature Date **Parent/Guardian's Printed Name**

_____ _____

Patient's Signature (if 18 or older) **Date** **Patient's Printed Name**

Child's Name	Date of Birth	Medical Card or Insurance Name	Medical Card or Insurance Number
		□ **CareSource** □ **United** □ **Molina** □ **Paramount** □ **Buckeye** □ **Other**_____	**ID#** **MMIS#**

School-Based Health Center
Student Information

In order to provide health services for your child, we need the following information:

Parent/Guardian Name: _____Parent/Guardian's Date of Birth: _____

Relationship to Child: _____ Parent/Guardian's Social Security No.: _____

Address: _____

Home Phone: _____Cell Phone: _____Work Phone: _____

Emergency Contact Person: _____ Phone Number: _____

Regular Medical Doctor or Clinic: _____

Address _____Phone #: _____

Date of last complete yearly physical examination (head to toe): _____

Regular Dentist/Clinic: _____ Phone #: _____

Date of last routine dental check-up: _____

Do you want a copy of the physical exam to go to your clinic or doctor? Yes _____ No_____

Preferred Pharmacy: _____ Pharmacy Phone #: _____

Parent/Guardian Signature_____ Date of Signature_____

Cincinnati Public Schools

Health History Update: 2016-17

Please complete and return to the school nurse or office. Thank you.
Ohio State Law requires that a Health History form be on file for every student.

_____ _____ _____/_____
Student's Name Date of Birth Grade/Homeroom

_____ _____ _____
Doctor's Name Phone Number Last checkup or visit

_____ _____ _____
Dentist's Name Phone Number Last checkup or visit

Insurance: ____Medicaid (circle: CareSource/ Molina/ United Health Care/ Paramount/ Buckeye)

____Private Name_____

____None

Any history of the following problems? (Please circle **Y** for Yes or **N** for No)

History For Student and then Family	Student	Family
Allergies: Seasonal/Hay fever	Y N	Y N
Life Threatening Allergy to:_____ EpiPen prescribed	Y N Y N	
ADD/ADHD	Y N	Y N
Anemia or Other Blood Problems	Y N	Y N
Asthma	Y N	Y N
Behavioral Problems _____	Y N	Y N
Blood Pressure Problems (High/Low)	Y N	Y N
Developmental Problems _____	Y N	
Cancer – type _____	Y N	Y N
Chronic Diarrhea or Constipation	Y N	Y N
Chronic Ear Infections	Y N	
Depression	Y N	Y N
Diabetes	Y N	Y N
Drugs or Alcohol Used During Pregnancy	Y N	
Eczema/Chronic Skin Condition	Y N	Y N

History For Student and then Family	Student	Family
Emotional/Psychological Problems	Y N	Y N
Frequent Headaches Head Injury/ Concussion	Y N Y N	Y N
Frequent Stomachaches	Y N	Y N
Hearing Problems	Y N	Y N
Heart Disease – type _____	Y N	Y N
Kidney Disease – type _____	Y N	Y N
Learning problems _____	Y N	Y N
Prematurity or Birth Weight under 5 lb.	Y N	
Seizure Disorder/Epilepsy/Tics	Y N	Y N
Sickle Cell Disease	Y N	Y N
Sleep Problems	Y N	Y N
Speech Problems	Y N	Y N
Toothaches/Dental Problems	Y N	Y N
Problems with Vision Wears Glasses	Y N Y N	Y N
Surgery what type:_____	Y N	

Tuberculosis (TB) Risk Assessment:

Is your student in contact with any of the following persons: Immigrants from another country, someone diagnosed with or treated for TB, incarcerated children or adults, HIV infected, homeless, nursing home residents, institutionalized children or adults, illegal drug users, migrant farm workers?
For your student/student, please circle yes or no below, and explain any yes answers in space provided.
Diagnosed or treated for TB? ___No ___Yes _____
Immigration from another country? ___No ___Yes _____
Traveled to another country? ___No ___Yes _____
Ever been in jail or in 20/20 juvenile center? ___No ___Yes_____

Student Name:_____

Please list any **CURRENT** health problems or conditions your student has (may be same as above): _____
_____

Please list any allergies (include **food, medications, environmental, seasonal,** etc.): _____

_____

Does your student see a specialist? If yes, please list condition, doctor's name, and phone number: _____

_____

Please list any medications (prescribed or over-the-counter) your student takes **at home** on a daily or as-needed basis (such as medication for ADHD, allergies, asthma, or headaches): _____

_____

SPECIAL NOTE: If your student needs to take any medications at school, including emergency medications (like an inhaler or Epi Pen), you must complete a CPS Administration of Medication form. ***Revised 4/2016***

Has your student had any operations, serious injuries or overnight hospital stays? No ___Yes ____; please explain:
_____

Has your student ever been pregnant? No ___Yes ____; please explain:
_____

Has your student had any operations, serious injuries or overnight hospital stays? No ___Yes ____; please explain:
_____

Has your student ever been a victim of abuse? No ___Yes ____; please explain:
_____

Has anything bad, scary or sad happened to your family? No ___Yes ____; please explain:
_____

School Concerns

Is your student in a special education class? No ___Yes ____; please explain: _____

Has your student repeated a grade? No ___Yes ____; details: _____

Does your student get into trouble at school? No ___Yes ____; details: _____

What are your student's grades on the report card? _____

Any changes recently in grades? No ___ Yes ___

Signature of Parent/Guardian _____ Date _____

How can we reach you during school hours? Cell:_____ Work_____ other_____

city of CINCINNATI HEALTH DEPARTMENT
We know **health** matters

Consent for Nitrous Oxide Sedation
Student Name:_____

If your child needs dental treatment, it may be beneficial or necessary to use nitrous oxide sedation in order to complete the dental treatment. Nitrous oxide relaxes children, makes them more comfortable, and gives them an all-around better experience at their dental appointment. By signing this form ahead of time, it will be easier for us to do the treatment in a more timely and efficient manner. We will attempt to call you prior to using nitrous oxide on your child. Please read the following and sign at the bottom if you consent to treatment with nitrous oxide sedation. It will only be used if necessary.

I give permission for a Cincinnati Health Department dentist to give my child nitrous oxide sedation if indicated. I understand that some side effects could occur including:

1. Nausea and vomiting. We suggest that no food be eaten for at least two hours before the appointment.
2. Excessive sweating, and the patient may get red or flushed.
3. An unusually high amount of saliva produced in the mouth.
4. Although not common, patient may get a sensation of having the chills.
5. In unusual circumstances, a child may become temporarily hyperactive.

The benefits include relaxation and possibly eliminating the need for local anesthetic injections ("Novocaine"). For those patients who may need both, the use of nitrous oxide/oxygen will make the injections much easier for the patient.

At no time will the patient be "asleep," and at all times the patient will be given more oxygen than what is present in room air. Patients will be monitored continually by the dentist and staff, and **a parent can be present as well if requested**.

If you would like to be present, please make a note on the top of this form, and we will be happy to schedule an appointment at your convenience.

☐ I consent for my child to receive nitrous oxide sedation as deemed necessary by the dentist. I understand the dental staff will attempt to contact me prior to administering nitrous oxide.

☐ I do not consent for my child to receive nitrous oxide sedation.

_____

Signature (Parent/Guardian) Phone Number Date

THE FOLLOWING PAGES ARE FOR YOU TO REVIEW AND KEEP FOR YOUR RECORDS

Program Description
School-Based Health Center
Cincinnati Health Department

Welcome to the School-Based Health Center. The School-Based Health Center makes medical, dental and vision care available to all students when needed. If your child/adolescent becomes sick at school or if your child/adolescent needs a check-up, sports physical, immunizations, routine dental care, or a vision exam they can have it done in the School-Based Health Center. If your child/adolescent develops a dental problem at school, a dentist can see your child at the Cincinnati Health Department (CHD) Price Hill Health Center (PHHC) or on the CincySmiles Dental Road Crew.

How the School-Based Health Center (SBHC) works:

- You must complete the attached consent form and the other information pages and return them to the school nurse or school office.
- You or your child may schedule an appointment in the SBHC if your child is sick or injured. You can also schedule an appointment for physicals, immunizations, required sports or employment physicals, dental care, eye exams, and all associated health care concerns .Any necessary prescriptions will be provided.
- After your child's visit with the provider or dentist, attempts will be made to contact you as necessary. .
- **The School-Based Health Center does not take the place of your regular doctor and joining the program does not mean you are changing your child's doctor.** You will be encouraged to have any needed follow-up care with that physician and a summary of your child's visit at CHD will be sent to that office. However, if you do not have a regular doctor, we welcome that relationship here and can become your child's doctor. If your child is already a patient of and CHD clinics, you still have to sign this consent to be a part of the School-Based Health Center.

Patient Rights and Responsibilities:

- Respectful and equal treatment, care, and accommodations are available regardless of race, age, ethnicity, creed, sex, or sexual orientation.
- To have a health-care assessment and plan of care, and to participate in your health-care plan.
- To talk to your health-care provider openly and privately.
- It is the patient's responsibility to carry out the recommended treatment plan.
- Allow at least 30 days for completion of insurance or disability forms and transfer of treatment records.
- Notify the SBHC if you have received treatment in an Emergency Room or hospital.
- After hours, in case of emergency, call 911, or go to the nearest emergency room. If you have an urgent issue and would like to speak with the provider on call, please call (513) 357-7320.

The PRIMARY HEALTH CARE SERVICES we may provide include:

- Ill visits (for example, for sore throat, rash, an asthma attack) and follow-up for medical problems, including physical examination, tests and treatment/medications as needed.
- Minor injury evaluation, including first aid.
- Routine physical examination (including sports and work physicals) with immunizations, routine tests and treatments as needed.
- Health education and wellness promotion.
- Referral to outside agencies for further care that cannot be provided at the School-Based Health Center.

The DENTAL HEALTH CARE SERVICES we may provide include:

- Routine dental examination and screenings, including dental health education and preventive services such as cleaning and dental sealants to help stop tooth decay.
- Problem visits (for example, for pain, infection or injury) or visits for urgent or emergency care, to include examination, x-rays, fillings, extractions (the pulling of loose or infected teeth), necessary treatment (including medication) for oral infection or other problems, and/or other procedures (including root canals on front teeth).

Regarding PAYMENT FOR SERVICES:

- If you do not have health insurance for your child, you will be responsible for the bill at the appropriate **discounted fee**. However, no child will be denied care due to inability to pay for services.
- If you do not have health insurance for your child, information about your household income will be requested to ensure compliance with federal requirements and to determine if you qualify for reduced or waived fees based on the Cincinnati Health Department sliding fee scale. This information will be kept strictly confidential.

- No child will be denied care due to inability to pay for services.
- We can help you if you need assistance applying for Medicaid. You can stop by our center, or call (513) 357-2787. You can also contact the Hamilton County Job and Family Services Department at (513) 946-1000.

Regarding the SHARING OF HEALTH INFORMATION:

- The School-Based Health Center may request medical records/information from any health care provider or facility where your child has been seen.
- Results of the visit will be sent by the School-Based Health Center to your child's regular doctor/clinic.
- The PHHC, School-Based Health Center and/or the Cincinnati Health Department (CHD) school nurse will share medical information with each other as needed.
- The child's medical and any other information will only be used in the treatment, payment and health care operations of the School-Based Health Center. All of your child's information will be kept strictly confidential according to all state and federal laws.
- The school has other community resources available, including mental health. If services for mental health are needed, the health center provider may initiate a referral to the mental health provider at your child's school or a community site. The mental health provider will contact your for consent. The health center provider and the mental health provider will coordinate your child's care as needed. All information will be kept strictly confidential.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, School-Based Health Center or the CHD may use and disclose protected health information, (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Cincinnati Health Department's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Cincinnati Health Department reserves the right to revise it Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Price Hill Health Center at 2136 W. Eighth Street, Cincinnati, OH 45204.
With my consent, School-Based Health Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, School-Based Health Center or CHD may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that School-Based Health Center or CHD restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to School-Based Health Center's uses and disclosure of my Protected Health Information to carry out treatment, payment and operation.

- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the School-Based Health Center may decline to provide treatment to me.

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* Please note that the School-Based Health Center is **completely optional.** School nursing and emergency services will still be provided as always whether you consent to the School-Based Health Center or not.

This consent will remain in effect until your child no longer is enrolled in Cincinnati Public Schools. You may revoke this consent for treatment at any time by requesting the School-Based Health Center, in writing, to have your child removed from the School-Based Health Center. **For changes in guardianship,** please notify us at the number below and in writing.

Please keep this Program Description for your records.

The School-Based Health Center is an excellent way to keep your child healthy and in school. Please let us know if there is anything keeping you from enrolling your child. If you have any questions or need help with the application, please call the School Health Program – (513) 357-2809 - or contact your school nurse.

Cincinnati Public Schools

Authorization for Administration of Over-the-Counter Medications at School

This form expires at the end of the current school year.

Student's Name	Date of Birth	School Year

Street Address	Apt. No.	City	State	Zip

School	Grade	Homeroom

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician/Nurse Practitioner/Dentist) **Complete dosage and frequency above

Provider's Signature: _____ Date: _____

Provider's Name: _____ Emergency Phone #: _____

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent/Guardian Date

_____

Please Print Name of Parent/Guardian

How can we reach you during school hours?

Work Phone	Home Phone	Cell Phone	Pager	Other

Cincinnati Public Schools

Over-the-Counter Medication Record 2016-17

FOR OFFICE USE ONLY. Use one form per Over-the-Counter Medication.

Student's Name: _____ Weight: _____ Date of weight_____
Medication: _____ Dosage:_____ Route:_____ Frequency:_____
(No Students days are gray on this calendar.)

AUGUST 2016				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

SEPTEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

OCTOBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

NOVEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30		

DECEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

JANUARY 2017				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

FEBRUARY 2017				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28			

MARCH				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31

APRIL				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28

MAY				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

JUNE				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

Signatures:

_____ Initials _____
_____ Initials _____

Signatures:

_____ Initials _____
_____ Initials _____

Type: Mist or IM
Doses: 1 or 2

Cincinnati Health Department
School and Adolescent Health
Consent Form for 2016-17 Seasonal Influenza Vaccine

COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME_____

STUDENT NAME (Last)	(First)			(M.I.)	GRADE / HOMEROOM
DATE OF BIRTH	AGE	GENDER M / F	RACE	PHONE NUMBER	
STREET ADDRESS	CITY		STATE	ZIP	

INSURANCE STATUS:
□ **Medicaid** □ **Caresource** □ **United Healthcare Community Plan** □ **Molina** □ **Paramount** □ **Buckeye**
□ **No Insurance** □ **Private Insurance** _____ □ **Other**_____
Medical Card Billing Number# _____ **Child's SS#**_____
No student will be denied the flu vaccine due to inability to pay or lack of insurance.

B. In order to determine if your child needs a booster dose, please answer this question**:**

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010? □ Yes □ No □ Unsure

C. Please answer all of the following questions:

	YES	NO
1. Is the student sick today with fever or respiratory illness?	□	□
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	□	□
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	□	□
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	□	□

D. Please answer all of the following questions:

	YES	NO
1. Does the student have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	□	□
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health-care provider told you that he or she had wheezing or asthma?	□	□
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	□	□
4. Does the person have close contact with someone who needs care in a protected environment? (For example, someone who has recently had a bone marrow transplant?)	□	□
5. Is the person on long-term aspirin or aspirin-containing therapy? (For example, does the person take aspirin every day?)	□	□
6. Is the student receiving anti-viral medications?	□	□
7. Is the person pregnant or could become pregnant in the next month?	□	□
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or FluMist? If yes, give type and date. Recent Vaccinations: _____Date received: _____	□	□

E. Consent

CONSENT FOR VACCINATION:
I understand I will receive the **2016 Flu Vaccine Information Statement** and be offered the **Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.**

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____
Print Name of Parent Legal/Guardian_____
Parent Cell Phone Number: _____

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY):

Vaccine	Date Dose Administered	Route	Lot Number	Name and Title of Vaccine Administrator
2016 Seasonal Flu	/ /2016	□Intranasal		
		□ IM		
Booster Dose	/ /201	□Intranasal		
		□ IM		