



2025-2026  
Forest Rose School – Early Childhood Center  
**CONTACT INFORMATION**

Student Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

**Please list student's parents or legal guardian(s) in the preferred contact order:**

1) Name: _____	2) Name: _____
Relationship: _____	Relationship: _____
Primary Phone: _____	Primary Phone: _____
Secondary Phone: _____	Secondary Phone: _____
Email: _____	Email: _____

Student resides with: ☐ mother and father ☐ mother only ☐ father only ☐ other: \_\_\_\_\_

Please communicate any important family information such as restraining orders, custody arrangements, guardianship, etc. – supporting documentation required.

**In an emergency, please list alternate person(s) to contact if person(s) above cannot be reached:**

1) Name: _____	2) Name: _____
Relationship: _____	Relationship: _____
Primary Phone: _____	Primary Phone: _____
Secondary Phone: _____	Secondary Phone: _____

**List below people who have your permission to pick the student up from Forest Rose School:**

<u>Full Name</u>	<u>Phone Number</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Student's Home Care Provider / Agency (if applicable): \_\_\_\_\_

Agency contact person's name: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Emergency Medical Authorization** 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.

Student First Name	Middle Name	Last Name
Street Address		P.O. Box
City	County	
Date of Birth	Gender	Male      Female
<b>The student resides with:</b>		
1) Name	2) Name	
Relationship	Relationship	
Primary Phone	Primary Phone	
Secondary Phone	Secondary Phone	
Marital Status - The student's natural parents are:      Married      Divorced      Separated      Widowed      Never Married If parents are divorced, please check here for permission to contact the student's non-custodial parent in case of illness, injury or emergency. It is the responsibility of the parent to provide current information regarding any court orders that are on file for the student. Name of Non-Custodial Parent _____ Phone Number _____		

Please list alternate person(s) to contact in case neither parent can be reached:

Name	Name
Relationship	Relationship
Primary Phone	Primary Phone
Secondary Phone	Secondary Phone

Medical Consent: I hereby give my consent for the medical staff at Forest Rose School to perform basic medical treatment for my child as necessary.      Consent given      Consent Denied

Preferred Physician: \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Dentist: \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Specialist: \_\_\_\_\_ Phone \_\_\_\_\_

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give consent for: (1) the administration of any treatment deemed necessary by the doctors named above, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to another hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless 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. Child's Medical History - Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies: \_\_\_\_\_ Medications: \_\_\_\_\_

Physical Impairments: \_\_\_\_\_ Other Pertinent Information: \_\_\_\_\_

**A signature is REQUIRED on ONE of the following portions of this form or it will be returned to you for completion:**

**PART I: TO GRANT CONSENT**

**OR**

**PART II: REFUSAL TO CONSENT**

I hereby give consent for the medical care providers and local hospital listed above to be called and for healthcare concerns to be shared with faculty & staff.

I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

Note: It is the parent's responsibility to notify the school of any change in information. The school **does not** provide accident/injury insurance. Financial obligations for medical expenses are a parent/student/athlete responsibility.

HEALTH INFORMATION  
TO BE COMPLETED EACH SCHOOL YEAR  
School year 2025-2026

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD

Normal Temperature \_\_\_\_\_°F

☐ **ALLERGIES**

**Allergy Type:**

- ☐ Medications \_\_\_\_\_  
☐ Food List food(s) \_\_\_\_\_  
☐ Bee Sting ☐ Other (list) \_\_\_\_\_

**Reactions:**

- ☐ Coughing ☐ Hives ☐ Rash ☐ Difficulty breathing ☐ Local Swelling  
☐ Wheezing ☐ Generalized Swelling ☐ Nausea ☐ Other \_\_\_\_\_

**Currently prescribed treatments to be used IN SCHOOL:**

- ☐ Oral antihistamine (Benadryl, etc.) ☐ Epi-pen ☐ Other \_\_\_\_\_
- .....

☐ **ASTHMA**

**Triggers:**

- ☐ Exercise ☐ Environment ☐ Others (list) \_\_\_\_\_

**Physical Education Restrictions:** ☐ None ☐ Self-Limits ☐ Other \_\_\_\_\_

**Symptoms or Reactions:**

- ☐ Chest tightness, discomfort, or pain ☐ Difficulty Breathing ☐ Wheezing  
☐ Throat itch, tightness, or soreness ☐ Hoarseness ☐ Other \_\_\_\_\_

**Currently prescribed treatment to be used in School:**

- ☐ Inhaler ☐ Oral antihistamine ☐ Oral Steroids ☐ Nebulizer  
☐ Peak flow monitoring ☐ Oral Bronchodilator

Date of last hospitalization related to Asthma \_\_\_\_\_

☐ **DIABETES**

**Currently prescribed treatment to be used in School:**

- ☐ Insulin ☐ Syringe ☐ Pen ☐ Pump ☐ Blood Sugar Testing ☐ Glucagon  
☐ Oral medication(s) List medicine(s) \_\_\_\_\_
- .....

☐ **SEIZURE DISORDER**

**Type of Seizure**

- ☐ Absence (staring, unresponsive) ☐ Complex Partial ☐ Generalized (Grand Mal/Convulsive)  
☐ Other (Explain) \_\_\_\_\_

☐ Physical Education Restrictions ☐ Yes ☐ No Date of Last Seizure \_\_\_\_\_

Length of Last Seizure \_\_\_\_\_

List Medications \_\_\_\_\_

.....

☐ **OTHER HEALTH CONDITIONS**

- ☐ Cancer ☐ Hemophilia ☐ Heart Condition ☐ Physical Disability  
☐ Other (Explain) \_\_\_\_\_

☐ Specialized procedure(s) (i.e. catheterization, etc.) required IN SCHOOL: ☐ No ☐ Yes (Explain) \_\_\_\_\_

List Medications \_\_\_\_\_

.....

**FOREST ROSE SCHOOL  
TRANSPORTATION INFORMATION / REQUEST**

**Please complete all information on the FRONT AND BACK of this form**

Student Name \_\_\_\_\_ Today's date \_\_\_\_\_

Date of Birth \_\_\_\_\_ ☐ Male ☐ Female

**I want my child to ride the bus while attending Forest Rose School**

☐ Yes ☐ No

	Morning (AM) Only	Afternoon (PM) Only	Both AM and PM
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Date of Request  
\_\_\_\_\_

\_\_\_\_\_ New request

\_\_\_\_\_ Change

\_\_\_\_\_ Cancel

**MORNING**

Address where student should be picked up

**AFTERNOON**

Address where student should be dropped off

**List below people who have your permission to get the student off the bus.**

Full Name

Phone Number

Relationship

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**COMMUNITY BASED EDUCATION (Field Trips)**

The student has my permission to ride a bus for field trips ☐ Yes ☐ No

The student has my permission to ride in a FCBDD owned vehicle, driven only by appropriately trained FCBDD staff for field trips ☐ Yes ☐ No

**PASSENGER ASSESSMENT QUESTIONS** (Needed for field trips, not just daily bus riding)

**Does the student have a Do Not Resuscitate Order (DNR)?**      **Yes**              **No**

Do you give permission for FCBDD and/or Petermann Transportation to contact EMS for emergency treatment if needed?      ☐ Yes              ☐ No

\*EMS cannot honor the DNR request unless a properly signed copy is available to them; please submit a copy of the order to Forest Rose School

Does the student have and/or require any of the following:

☐ Wheelchair      ☐ Walker      ☐ Vest      ☐ Car Seat      ☐ Seatbelt      ☐ None

Can the student get on and off the bus without help, but needs supervision?      Yes              No

Is the student      Verbal              Non-verbal

Can the student understand and/or follow verbal instruction or sign language?      ☐ Yes      ☐ No

Please describe \_\_\_\_\_

Please check and explain all that apply to the student while being transported:

(Consider things like seizures, whether the student routinely remains seated, etc)

Medical concerns      ☐ Yes      \_\_\_\_\_

Behavior concerns      ☐ Yes      \_\_\_\_\_

Dietary concerns      ☐ Yes      \_\_\_\_\_

Physical limitations      ☐ Yes      \_\_\_\_\_

Seating restrictions      ☐ Yes      \_\_\_\_\_

List any other concerns      \_\_\_\_\_

**Parent's Signature** \_\_\_\_\_

Home \_\_\_\_\_

Parent's Name Printed \_\_\_\_\_

Cell \_\_\_\_\_

Date \_\_\_\_\_

Work \_\_\_\_\_

.....  
\_\_\_\_\_ Approved      Date to begin \_\_\_\_\_      Vehicle operator \_\_\_\_\_

Approximate time for pick up \_\_\_\_\_      Drop off \_\_\_\_\_

Special considerations \_\_\_\_\_

Transportation Supervisor \_\_\_\_\_ Date \_\_\_\_\_



## Forest Rose School Permission Form School year 2025-2026

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please read over and initial each section.

Permission Granted	Permission Denied
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**Photo Release:** Forest Rose School and The Fairfield County Board of Developmental Disabilities (FCBDD) occasionally use photos of our students for purposes of public awareness materials and community education, including but not limited to brochures, videos, display boards, annual report, social media, website, print advertising and levy promotions.

**Photo/Artwork Release:** Forest Rose School recognizes that our students are often deserving of recognition; therefore, when appropriate we may publish their photograph and/or artwork in publications that include but are not limited to the local newspaper, social media, website, school publication or art show.

**Forest Rose Roster:** A parent's name and address would be included in the roster along with the student's name. A roster would only be provided to a parent upon written request and only to that parent.

**ISC Invitations:** Forest Rose School has permission to contact my child's ISC (Individual Service Coordinator) for any meetings regarding my child.

**School Delay/Closure Notification:** I wish to be included in the school delay/closure notification system.

**The phone number to be used for notification is** \_\_\_\_\_.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent's Printed Name

# ILLNESS GUIDELINES

It is the goal of the Fairfield County Board of Developmental Disabilities (FCBDD) to provide a healthy and safe environment for all individuals we serve and for staff members. While we recognize that at times it may be inconvenient to make arrangements to care for a sick child, we ask you to respectfully consider the medically fragile children we serve and to assist us in preventing the spread of illness. The following represent the more common illnesses and the recommendations of the FCBDD nursing staff on when to stay/send home and for how long:

COVID 19: Generally, student displays symptoms of sore throat, cough, fever, allergy-like symptoms. If the student is displaying symptoms of COVID 19 or we have reason to believe the student has been exposed, the school nurse will administer a rapid test at school. The school nurse will call the parents for any student testing positive. Any child displaying symptoms or having a known exposure should be kept home from school.

Students may return to school 10 days after exposure/symptoms began and he/she is without symptoms, without the aid of medications, for 24 hours.

Chicken Pox: A skin rash consisting of small blisters which leave scabs. A slight fever may or may not be present. There may be blisters and scabs present. The student must remain home until all blisters have scabbed over; usually 5-7 days after the appearance of the first crop.

Cold Sores: Fluid-filled blisters that may appear on the lips or under the nose. These blisters and the fluid they contain are highly contagious. After about 4 to 6 days, the sores start to crust over and heal. May return to school when crusted over.

Cold Symptoms (severe) or Sinus Infections: Irritated throat, watery discharge from the nose and eyes, sneezing, chills, and general body discomfort. The student must remain home if the symptoms are severe enough to interfere with the ability to learn or work; if discharge becomes yellow or green; if fever develops; or symptoms persist beyond 7 days. Medical care should be obtained with the onset of any of these symptoms.

The student should not return to work or school until antibiotics have been administered for at least 24 hours.

Diarrhea (Intestinal Tract Infections): Parents/Guardians will be called to pick up student after 2<sup>nd</sup> time of having diarrhea at school. Stomachache, cramping, nausea, diarrhea (with or without fever), headache and body aches. The student must remain home until he/she has been without fever or diarrhea for a full 24 hours without use of medication for treating such symptoms. If the student experiences any of these symptoms during the night, he/she must not be sent to school the following day. *If student has had Laxatives (not part of their regular medication routine) at home the night before school or the morning of school, the student must not return to school until after results are achieved.*

Ear Infections: Due to the discomfort, general malaise and compromised immune system that accompany this condition, your child should remain home for at least 24 hours following being placed on antibiotics, pain relieving eardrops or other inflammation reducing medications. This gives your child's body a chance to recover so as not to interfere with his/her ability to learn.

Fever: If the student's temperature is 100 degrees Fahrenheit or greater (or 1-2 degrees above the student's normal body temperature), the student must remain home until he/she has been without fever for a full 24 hours, without the use of any fever-reducing medications. Remember, fever is a symptom indicating the presence of an illness and the student is usually uncomfortable in the presence of fever.

Flu: Abrupt onset of fever, chills, headache and sore muscles, running nose, sore throat, and cough are common. The student must remain home until the symptoms are gone and he/she is without fever, without the aid of fever-reducing medications, for 24 hours.

Head Lice: Lice are small, grayish-tan, wingless insects that lay eggs called nits. Nits are much easier to detect than live lice. They are small white specks, which are usually at the nape of the neck and behind the ears.

Following lice infestation, the student must be kept home until treatment with a pediculicide shampoo is complete and all nits have been removed. When the student returns, the parent/guardian must bring the student to the school nurse prior to being able to return to class.

Impetigo: Blister-like lesions, which later develop into crusted pus-like sores. The student must remain home until having received a minimum 24 hours treatment with an antibiotic AND sores are no longer draining.

Pain: If the student complains of or indicates that he/she is experiencing persistent, ongoing pain, the student should be evaluated by a physician before being sent to school.

Pinkeye: Redness and swelling of the membrane of the eyes with burning or itching, matter coming from one or both eyes, or crusts on eyelids. The student must remain home until having received a full 24 hours of antibiotic therapy AND the discharge from the eyes has stopped. Spread of infection can be minimized by keeping the hands away from the face, good hand washing practices, using individual or disposable washcloths and towels and NOT touching any part of the eye with the tip of the medication applicator while administering the antibiotic drops or ointment.

Scabies: Scabies is a skin infestation caused by microscopic parasites called mites. The mites burrow under the skin creating small, raised areas. The burrows, which contain fluid, resemble wavy lines and appear frequently on finger webs or on the wrists, elbows, breasts, beltline, thighs and abdomen. A rash may occur anywhere on the body, regardless of the area of infestation. Itching is intense, especially at night. Infected persons must be treated with a prescription product as soon as possible after diagnosis. Follow the instructions on the medication exactly. The infested person should avoid social situations, including work or school, until 24 hours after the first treatment. Itching may persist for 1-2 weeks after treatment; this should not be taken as a sign of treatment failure. Over treating should be avoided because the medication can be toxic.

Skin Rashes: The nurses will exclude any student with an undiagnosed skin rash. Please do not ask the nurses to diagnose the rash, as they are not able to do so by law. A physician should evaluate skin rashes of undiagnosed origin before the student is sent back to school. We must also have a note from the doctor releasing the student to return.

Strep Throat and Scarlet Fever: Strep throat begins with fever, sore and red throat, may or may not have pus spots on the back of the throat and tender, swollen glands on the neck. Scarlet fever has all the same symptoms as strep throat as well as a strawberry appearance to the tongue and rash on the skin. High fever, nausea and vomiting may also occur. The student must remain home from school until they have received a full 24 hours of antibiotic therapy and until they have been without fever or vomiting for 24 hours without the use of medication for such. Most physicians advise rest at home for 1-2 days after strep throat. It is important that antibiotics for a strep infection are to be taken for the full length of the prescribed course of treatment or until all medication is gone. Only when these directions are followed correctly is the strep germ completely eliminated from the body, no matter how well the child feels after the first few days of receiving medication.

Vomiting (Intestinal Tract Infections): Parents/Guardians will be called to pick up student after 1 time of vomiting. Stomachache, cramping, nausea, vomiting (with or without fever), headache and body aches. The student must remain home until he/she has been without fever and without vomiting for a full 24 hours without use of medication for treating such symptoms. If the student experiences any of these symptoms during the night, he/she must not be sent to school the following day.



## ILLNESS GUIDELINES AGREEMENT AND MEDICAL CONSENT

I have received and reviewed a copy of the “Illness Guidelines” (pages attached). I understand that my child **should remain at home and/or will be sent home by FCBDD nursing staff** if he/she exhibits signs of sickness under these guidelines. **I understand it is my responsibility to have my child picked up/removed from school within one hour of notification from nursing staff.** I also give the nursing staff permission to administer a COVID-19 rapid test if they deem it necessary.

I understand that after two unsuccessful attempts to reach me, the nursing staff will contact the individuals listed on the emergency contact list who I have given permission to pick up my child.

I understand that should a student be hospitalized or seen in an emergency room or urgent care facility for any reason, a note must be signed by a physician for the student to return to school. The note should also include special restrictions and/or care instructions. I understand that if the student is out of school for five (5) or more days, it is requested that the parent/guardian call the school and give them an update on the student.

I understand that if my child is to be absent for any reason, I am to call the school office at 740-652-7225 as soon as possible to inform them.

**IN ADDITION**, I give permission for the nursing staff at FCBDD/Forest Rose School to contact the student’s physician to discuss medication and/or medical needs.

Student’s Name: \_\_\_\_\_

Parent’s Signature: \_\_\_\_\_

Parent’s Name Printed: \_\_\_\_\_

Date: \_\_\_\_\_



**FOREST ROSE SCHOOL - EARLY CHILDHOOD CENTER**  
Medication List 2025-2026 school year

**Student Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**List all prescription, over the counter and/or herbal medication the student takes regularly**

Name/Description	Dose	Frequency	Reason for Administration	Possible Reactions

**Parent signature** \_\_\_\_\_ **Today's date** \_\_\_\_\_



Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Nutritional Information

2025-2026

### Does your child have a

Regular Diet

Special Diet – please describe \_\_\_\_\_

Supplemental Nutrition – please describe \_\_\_\_\_

G Tube

J Tube

GJ Tube

Oral Aversion – please describe \_\_\_\_\_

### Does your child eat by mouth

Yes, for all nutrition

Yes, for some nutrition but also has a tube feed

Yes, but must be a certain consistency \_\_\_\_\_

No, nothing by mouth

### If your child is tube fed, please fill out below

#### What type of nutrition or diet does your child follow

Formula \_\_\_\_\_

Blended Foods \_\_\_\_\_

Ketogenic \_\_\_\_\_

Other \_\_\_\_\_

### If your child has a bolus feed

How often \_\_\_\_\_ Amount per bolus \_\_\_\_\_ Flush volume \_\_\_\_\_

### If your child has a continuous feed

How many hours per day \_\_\_\_\_ Rate \_\_\_\_\_ Flush volume \_\_\_\_\_

### Special Instructions



## NOTICE OF HEARING, VISION, AND DENTAL SCREENINGS AT FOREST ROSE SCHOOL

Schools providing medical services are required to screen school-aged students for hearing and vision. The Ohio Department of Health (ODH) sets the requirements for what grades are to receive hearing and vision screenings each year; what equipment is acceptable to use; what specific hearing and vision tests are needed to perform the screenings; and the referral criteria. Preschool, kindergarten, first, third, fifth, seventh, ninth, and eleventh grades as well as new students are screened annually by our school nurses. They can also provide screenings if a teacher or parent thinks there may be an issue.

If your child does not pass the school's hearing or vision screening, you will receive notification; a referral letter will recommend that you take your child for a comprehensive evaluation by a vision or hearing specialist. If you do not receive a referral letter from the school nurses, please assume that your child passed the screenings.

The school's hearing and vision screenings provide only a snapshot of how your child performs on the day the test was administered and is not a substitute for a complete eye exam by an optometrist or ophthalmologist, or a complete hearing evaluation by an audiologist. If your child has had a recent visit to a vision or hearing specialist, we ask that you please send in a summary of the visit for your child's file.

### **DENTAL SCREENINGS**

We try to provide an opportunity each year for our students to have a dental screening at the school by Ohio Dental Outreach Mobile Dentists. To learn more about this program go to [mobiledentists.com](http://mobiledentists.com). Permission forms will be sent out 3 to 4 weeks prior to the scheduled screening date.

By signing below, you have *acknowledged receipt* of this notice. If you have any questions or concerns, please feel free to contact the school nurses at 740-652-3707.

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Student Name

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Parent Signature

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Date

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Parent Name Printed

6/1/2023



## EQUIPMENT CONSENT FORM

### 2025-2026

Student Name: \_\_\_\_\_

If your child receives any type of therapy services while at school, you are aware that therapists and staff utilize some type of special equipment while working with your child, both during therapy and out, to improve academic performance as well as physical well-being. This equipment is typically the property of the Fairfield County Board of Developmental Disabilities. We work very hard to keep our equipment safe, up-to-date, and in top working condition to optimize the benefit to our students.

Please read the statements below and sign if you are in agreement:

- I agree that I understand that my child may be using specialized equipment at school, which has not been purchased specifically for my child, but that is in sound working condition, and is appropriate to meet his/her needs.
- I have the right to inspect the equipment prior to my child using it.
- The equipment will be used only as instructed or intended by a referring therapist.
- I understand that there may be risks, including the risk of personal injury; however, I release, waive, discharge and covenant not to sue Fairfield County Board of DD, its officers and employees from any and all liability to me, my child, and our heirs for any claims, demands, losses or damages due to an accident or injury caused or alleged to be caused by any use of equipment.
- This consent is valid for 1 year from the date signed below.

Parent/Guardian Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## BEHAVIOR SUPPORT 2025-2026

Many of our students use behavior as a primary means of communication. Our goal is to promote the development of language and prosocial behaviors that support students across all environments—academic, social, and daily living. Forest Rose will use an internal Positive Behavior Support Team to work across all classrooms, providing support at both the group and individual levels, based on student needs.

The Positive Behavior Support Team will use proactive, research-based strategies and follow a structured process that includes:

- ❖ Observing and identifying maladaptive behaviors (e.g., what the behaviors are, how frequently they occur, under what conditions, and their intensity)
- ❖ Collaborating with classroom staff to develop individualized positive behavior support plans
- ❖ Assisting with the implementation of those plans
- ❖ Monitoring progress and adjusting supports as needed

Our ultimate goal is to create a supportive and consistent learning environment where every student can thrive socially, emotionally, and academically.

***By signing below you are in agreement with the following:***

I UNDERSTAND that Fairfield DD and Forest Rose School follow behavior support rules set forth by the Ohio Department of Developmental Disabilities which always attempt positive supports before considering more restrictive measures. Any restrictive measures (including restraint and seclusion) may only be utilized in an emergency for health and safety purposes. Each incident must be documented and parents/guardians notified in writing. A determination for ongoing use must be approved by the Human Rights Committee.

I UNDERSTAND that Fairfield DD and Forest Rose School follow behavior support rules set forth by the Ohio Department of Developmental Disabilities which also means that there are limitations to the types of behavior strategies that can be used in the school as well as the demands we can place on students.

I UNDERSTAND that by attending Forest Rose School, *positive* behavior support interventions will be used to promote prosocial behaviors with my child and are a part of normal operating procedure at Forest Rose School.

I UNDERSTAND that should the internal behavior support team need additional support, Fairfield DD's Behavior Support Services Department will be consulted. Parents/guardians will be contacted for a meeting should the need for discussion of restrictions become necessary.

FINALLY, I UNDERSTAND that Forest Rose is dedicated to serving medically fragile students or those requiring specialized educational services beyond what their local school district can provide. However, if a student can no longer be appropriately served at Forest Rose—either due to a lack of progress or because they consistently engage in behaviors that pose a risk to their own safety or the safety and welfare of others—Forest Rose reserves the right to initiate an IEP team meeting to discuss a student’s placement at Forest Rose. Furthermore, it is the responsibility of the District of Residence to present alternative placement options.

Student Name: \_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# **PLEASE READ**

Dear Parents/Guardians:

The following forms will need to be provided to your child's physician as they each require a doctor's signature. Some of the forms require your signature as well, so please sign them prior to giving them to your doctor.

If any of the attached forms do not pertain to your child, please draw an X or a line through the page or write N/A so we know that the form was not overlooked.

As a reminder, preschool students require a physical once a year. We require a physical for school age students once every three years.

Thank You!

Forest Rose School

**ATTENTION DOCTORS**

**Please fax signed forms to**

**740-681-5731**





**FOREST ROSE SCHOOL - PHYSICAL EXAM FORM  
2025-2026**

Students Name	Date of Birth
Full Address	
Parent or Guardian:	
Primary Phone	Secondary Phone

**Required** for children enrolled in an Early Childhood Education Grant Program or Preschool Special Ed Program

Assessment/Screening	Date	Results	Reason if not given
Vision			
Hearing			
Lead			
Hgb/Hct			

Height	Weight	Sex	Blood Pressure
Glasses	Yes      No      Other:		
Does the student have a history of ear infections?		Yes	No
Tubes	Yes      No	If yes, the Student has had them as of (date):	
Has a swallow study been performed on the student?		Yes	No
If yes, please list any recommendations			
Diet:		NPO	Yes      No
List any food or drug allergies:			
Any concerns or difficulties with bladder, bowel, bleeding / menstruation			

**LIST OR ATTACH A COPY OF ALL DIAGNOSES:**

	Normal	Explanation of Deviation
Ears (otoscopic)		
Eyes		
Lymph Glands		
Thyroid		
Nose/Throat		
Teeth-Mouth		
Heart		Murmur_____
Lungs		
Abdomen		
Hernia		
Genito-Urinary		
Orthopedic:	Structural	
	Posture	
	Scoliosis	
	Feet	
Skin		
Nervous System		
Speech		
Other		

**I certify that this student is free from apparent communicable disease and is in suitable condition to attend school based on his/her medical history and health at the time of the examination.**

\_\_\_\_\_  
Physician's Office Address (can be stamped)

**Physician's Signature**

**DATE OF PHYSICAL EXAM**



**FOREST ROSE SCHOOL - EARLY CHILDHOOD CENTER  
STUDENT / SCHOOL IMMUNIZATION RECORD  
2025-2026**

**Student's Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ (mm/dd/yyyy)

I certify that this student is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the minimum requirements for attending school or preschool prescribed by the Ohio Department of Health.

**Physician or Health Department Official's Signature**

**Physician or Health Department Official's Printed Name**

**Date**

**THE STUDENT'S PHYSICIAN OR A HEALTH DEPARTMENT OFFICIAL MUST SIGN ABOVE AND EITHER COMPLETE THE SECTION BELOW OR ATTACH A CURRENT IMMUNIZATION RECORD TO THIS FORM .**

**IMMUNIZATION**                      **Vaccine doses given - Record complete dates (mo, day, year)**

DTaP / DTP / DT / Tdap / Td Diphtheria, Tetanus, Pertussis	1	2	3	4	5
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Polio	1	2	3	4	5
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MMR Measles, Mumps, Rubella	1	2	3	4	5
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Hib <i>Haemophilus Influenzae</i> Type B	1	2	3	4	5
---	---	---	---	---	---

HEP B Hepatitis B	1	2	3	4	5
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Varicella (Chickenpox)	1	2	3	4	5
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# **Forest Rose School – Early Childhood Center** **Over the Counter Medication Authorization** **2025-2026**

All over the counter medication will be administered by nursing staff or appropriately trained staff at Forest Rose School and will be given according to the manufacturer’s instructions. Items marked \*\* must be brought in from home as needed; they are not kept on-hand. Any over the counter medication not listed below must be accompanied by a signed permission statement. All over the counter medication must come to school in the original container with the student’s name clearly marked on the container and must not be expired.

Student’s Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

<u>Name / Description of Item:</u>	<u>Okay to Administer:</u>	
Antiseptic Towelette (Benzalkonium Chloride)	Yes	No
Antacid (Tums)	Yes	No
Bactine	Yes	No
Band Aids – including a liquid band-aid	Yes	No
Benadryl	Yes	No
Chapped Lip Balm**	Yes	No
Cough/Cold Syrup**	Yes	No
Corticoool Gel (Hydrocortisone 1.0%)	Yes	No
Diaper Rash Ointment**	Yes	No
Gas Relief	Yes	No
Hydrogen Peroxide	Yes	No
Ibuprofen	Yes	No
Isopropyl Alcohol Wipes	Yes	No
Muscle Pain Reliever (Biofreeze, Icy Hot, etc)	Yes	No
Nasal Decongestants**	Yes	No
Orajel	Yes	No
Sterile Eye Wash	Yes	No
Sunscreen**	Yes	No
Sting Ease Swabs	Yes	No
Swimmers Ear Drops**	Yes	No
Tylenol**	Yes	No
Triple Antibiotic (Bacitracin, Neomycin, Polymyxin)	Yes	No
Vaseline	Yes	No
OTHER:	Yes	No
OTHER:	Yes	No

Parent’s Signature \_\_\_\_\_

Physician’s Signature \_\_\_\_\_

Date \_\_\_\_\_



**Forest Rose School – Early Childhood Center  
Swimming Information and Permission Slip  
2025-2026**

**Forest Rose School has a heated, indoor pool on-site; it is used for therapeutic swim time. The water temperature is 92 to 96 degrees daily. Due to the high temperature of the water both a parent/guardian's signature and a physician's signature are required on this form.**

The pool is seven yards square and the depth ranges from 1½ to 3 feet deep. Students are placed in swim groups based upon their ability and should be able to spend 20 minutes or longer in the pool. Staff members who supervise and interact with students in the pool are required to maintain current certification in CPR and First Aid. A copy of our Pool Procedures is available upon request.

**For Parent/Guardian Completion:**

I **GIVE** permission for (student's name) \_\_\_\_\_ to swim in the pool at Forest Rose School based on the information above.

My child has taken swimming lessons	Yes	No
My child is afraid or unsure of being in water	Yes	No

I **DO NOT GIVE** permission for (student's name) \_\_\_\_\_ to swim in the pool at Forest Rose School based on the information above. Physician completion not needed if your child will not be swimming.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date

**For Physician Completion:**

I give permission for (student's name) \_\_\_\_\_ to swim in the pool at Forest Rose School based on the information above.

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE**

\_\_\_\_\_  
**Physician's Name Printed**

\_\_\_\_\_  
Date

## Questionnaire for Parent of Student with Seizures School year 2025-2026

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form please contact your child's school nurse at 740-652-7225.

### Contact Information

Student's Name	Date of Birth	
Parent/ Guardian	Phone: Cell	Work
Emergency Contact	Phone: Cell	Work
Child's Neurologist	Phone	Location
Child's Primary Care Doctor	Phone	Location
Significant Medical History of Conditions		

### Seizure Information

When was your child diagnosed with seizures or epilepsy? \_\_\_\_\_

Seizure Type(s)

Seizure Type	Length	Frequency	Description

What might trigger a seizure in your child? \_\_\_\_\_

Are there any warnings and/or behavior changes before a seizure occurs?      YES      NO

If YES, What are they?

When was your child's last seizure? \_\_\_\_\_

Has there been any recent change in your child's seizure patterns?      YES      NO

If YES, please explain: \_\_\_\_\_

How does your child react after a seizure is over? \_\_\_\_\_

How do other illnesses affect you child's seizure control? \_\_\_\_\_

Are there any special first aid measures that should be taken when your child has a seizure?

## Seizure Emergencies

Please describe what constitutes an emergency for your child?

Has child ever been hospitalized for continuous seizures?

YES

NO

If YES please explain:

## Seizure Medication and Treatment Information

What medications does your child take?

Medication	Date started	Dosage	Time(s) given

What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration instructions (timing & method**)	What to do after administration

\*\*After 2nd or 3rd seizure, for cluster of seizures etc.

Should any particular reaction be watched for?

YES

NO

If YES, please explain:

Does your child have a Vagus Nerve Stimulator?

YES

NO

If YES, please describe instruction for appropriate magnet use:

## General Communications

Do you wish to be contacted if and when your child has a seizure?

YES

NO

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# **SEIZURE ACTION PLAN**

Effective Date \_\_\_\_\_

**THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST SCHOOL STAFF IF A SEIZURE OCCURS DURING SCHOOL HOURS.**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Significant medical history: \_\_\_\_\_

## **SEIZURE INFORMATION:**

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

Seizure triggers or warning signs: \_\_\_\_\_

Student's reaction to seizure: \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

How does your child react after a seizure? \_\_\_\_\_

How do other illnesses affect your child's seizure control? \_\_\_\_\_

Describe what constitutes an emergency for your child: \_\_\_\_\_

Has your child ever been hospitalized for his/her seizures? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

## **TREATMENT PROTOCOL DURING SCHOOL HOURS:** *(include daily and emergency medications)*

<i>Daily Medication</i>	<i>Dosage &amp; Time of Day Given</i>	<i>Common Side Effects &amp; Special Instructions</i>

Emergency/Rescue Medication \_\_\_\_\_

Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, describe magnet use: \_\_\_\_\_

## **SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS:** *(regarding school activities, sports, trips, etc.)*

\_\_\_\_\_  
**PHYSICIAN'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

\_\_\_\_\_  
**PARENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# Doctor's order Form

## School Year 2025-2026



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication or Treatment	Dose	Route	Time or Intervals to be Given	Reason for Medication or Treatment	Adverse Reactions or Side Effects to Report. (If not listed, the health care provider acknowledges there are none to be observed)	Start Date	Cease Date *

\* "Cease Date", at the end of current school year unless otherwise noted

Special instructions for dealing with adverse reactions: \_\_\_\_\_

Special instructions for medication/task (storage, sterile condition, refrigeration, etc.):

Physician Signature:	Date:
Physician Printed Name:	Phone:
Parent Signature:	Date:
Emergency Contact Numbers:	Forest Rose School Phone: 740-652-7225 Fax: 740-681-5731