2024-2025
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:_____
Relationship:_____
Primary Phone:_____
Secondary Phone:_____
Email:_____

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

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

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

Full Name	Phone Number	Relationship

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

Agency contact person's name: _____ Phone:_____

_____ _____
Parent/Guardian Signature Date

Rev 2023

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	

The student resides with:

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**

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.

_____

Signature of Parent/Guardian **Date**

PART II: REFUSAL TO CONSENT

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**

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 2024-2025

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

Date of Request
_____

_____New request

_____Change

_____Cancel

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			

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 2024-2025

Student Name:_____ Date of Birth:_____

Please read over and initial each section.

Permission Granted	Permission Denied	
☐	☐	**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 and Vomiting: (Intestinal Tract Infections): Stomach-ache, cramping, nausea, vomiting and/or diarrhea (with or without fever), headache and body aches. The student must remain home until he/she has been without fever, vomiting or diarrhea for a full 24 hours without medication for treating such conditions. If the student experiences any of these during the night, he/she must not be sent to school the following day.

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.

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, option 3 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 2024-2025 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

2024-2025

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. 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.

_____

Student Name

_____ _____

Parent Signature Date

_____

Parent Name Printed

6/1/2023

EQUIPMENT CONSENT FORM

2024-2025

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: _____

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. If any of the following 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

FAIRFIELD COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

FOREST ROSE SCHOOL - PHYSICAL EXAM FORM
2024-2025

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 / menstration			

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

Rev. 2023

FOREST ROSE SCHOOL - EARLY CHILDHOOD CENTER
STUDENT / SCHOOL IMMUNIZATION RECORD
2024-2025

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 Diptheria, Tetanus, Pertussis	1	2	3	4	5
Polio	1	2	3	4	5
MMR Measles, Mumps, Rubella	1	2	3	4	5
Hib *Haemophilus Influenzae* Type B	1	2	3	4	5
HEP B Hepatitis B	1	2	3	4	5
Varicella (Chickenpox)	1	2	3	4	5

Forest Rose School – Early Childhood Center
Over the Counter Medication Authorization
2024-2025

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 _____

Name / Description of Item:	Okay to Administer:	
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
Corticool 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
2024-2025

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 2024-2025

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:

Seizure Type	*Length*	*Frequency*	*Description*

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)*

Daily Medication	*Dosage & Time of Day Given*	*Common Side Effects & Special Instructions*

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 2024-2025

FAIRFIELD COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

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**

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