CLEVELAND METROPOLITAN SCHOOL DISTRICT

Integrated Health Services Department

August 30, 2023

Dear Parents/Guardians:

For your child to receive medication in school, you must:

- Return a completed (and attached) medication form every school year **or** register for the Metro School Health Program (SHP). If you choose to sign up for the Metro SHP, the nurse practitioner from Metro will complete the attached form for you every year. If you choose to sign up for the Metro SHP, I'm attaching a form for that too along with a flyer that describes the services that Metro has to offer. In any case, whether you choose to sign up for Metro or not, your child must have the attached Parental Request Form for Prescribed Medication completed and signed each year for your child to take any kind of medication in the school setting. (That includes over-the-counter medications like Tylenol and Advil.)
- All medications must remain in the properly labeled pharmacy container. Your pharmacy can provide a second, identically-labeled container for any prescription medications your child will take in school. (Over-the-counter medications like Tylenol and Advil also need to be in their store-bought containers.)
- If only half of the pill is to be given, then the pill must be cut by either you or the pharmacist. If there are any changes with the medication, dosage, or time to be given, a completely new medication form must be filled out, signed and returned to school.
- The parent/guardian is responsible for having the medication delivered directly to the school by an adult. **Students cannot transport medications without completed forms.**
- If your child has a rescue medication for respiratory conditions, an epinephrine auto injector, or insulin, glucagon, and related diabetes supplies, the health care provider must indicate on the (attached) medication form that the student may self-administer and/or carry the medication on his/her person.

If you have any questions, please contact me, your school nurse. Thank you.

Sincerely,

Nurse David
David Spanos, RN
Educator: School Nurse
Lincoln-West Campus
David.Spanos@ClevelandMetroSchools.Org
216.838.7107

CLEVELAND METROPOLITAN SCHOOL DISTRICT
Vision to Victory

PARENTAL REQUEST FORM
FOR PRESCRIBED MEDICATION

Student Name	aka	Student ID	Date of Birth
School Name		**Hours**	**Lunch Period**

Diagnosis/Reason for Medication(s):	
Name of Medication(s):	
Medication Form:	☐ TABLET/CAPSULE ☐ LIQUID ☐ INHALER ☐ INJECTION ☐ OTHER:
Special Storage Requirements:	☐ REFRIGERATE ☐ NONE ☐ OTHER:
Start Date:	
Stop Date:	☐ END OF SCHOOL YEAR ☐ FOR EPISODIC/EMERGENCY EVENTS ONLY ☐ OTHER/DURATION:

Instructions: (Schedule and dosage to be given; please include all medications taken daily)	AT SCHOOL:		TIME:	
	AT HOME:		TIME:	

Restrictions/Side Effects:	
Student Responsibility:	Is student capable and responsible for self-administering this medication? ☐ NO ☐ YES (SUPERVISED) ☐ YES (UNSUPERVISED) May student carry this medication? ☐ YES ☐ NO
Additional Information:	Please indicate if you have provided additional information: ☐ YES ☐ NO If so, describe:

Date: _____ **Signature:** _____ *(Authorized Provider)*

Physician Information:	PRINTED NAME:			
	ADDRESS:			
	PHONE #:		EMERGENCY #:	

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____, to receive the above medication at school according to the CMSD policy. It is understood that the CMSD and all of its school personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. It is also understood that by requesting CMSD personnel to administer medication to my child that I also allow the prescriber to communicate with the school nurse regarding my child's treatment plan.

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

Parent/Guardian Information:	PRINTED NAME:			
	ADDRESS:			
	HOME PHONE #:		WORK/EMERGENCY #:	

Reviewed by Nurse:	PRINTED NAME:		DATE REVIEWED:	

Student Name: _____ Student DOB: _____

CLEVELAND METROPOLITAN SCHOOL DISTRICT

SCHOOL-BASED HEALTH SERVICES CONSENT FORM

SAY YES TO EDUCATION CLEVELAND

Cleveland Metropolitan School District ("CMSD") and Say Yes Cleveland ("SYC") partner with community agencies to offer additional School-Based Health Services. Completion of this consent form is required for your child to receive these health services from CMSD partner health providers. **School nursing and emergency services will be provided whether or not you choose to take part in these added services.**

Student/Patient Information

Student Last Name: _____ Student First Name: _____

Date of Birth: _____ Sex at Birth (please check): ☐ Female ☐ Male Gender: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____ School Name: _____

Preferred Language: _____ Is this student Hispanic/Latino? (please check)? ☐ Yes ☐ No

Race (please check): ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Black/African American ☐ Don't want to answer Other: _____

Legal Guardian Information (This will be the primary person contacted concerning the student's health)

Guardian's Last Name: _____ Guardian's First Name: _____

Date of Birth: _____ Employer Name (if available): _____

Phone Number _____ Email _____

Relationship to Student _____ Lives with Student? ☐ Yes ☐ No

Student/Patient Insurance Information (If known)

Child/Teen has insurance (please check): ☐ Yes ☐ No

Name of Insurance Company: _____ Subscriber's Name: _____

Group Number: _____ Subscriber ID: _____

Emergency Contact Information (other than legal guardian)

Name: _____ Relationship to student: _____

Phone Number: _____ May we leave a message? ☐ Yes ☐ No

Student Health Information (to be completed by parent/legal guardian) Please check all that apply.

☐ Asthma	☐ Spine Disorders	☐ Blood Disorder	☐ Bowel Disorder
☐ Cancer/Leukemia	☐ Bladder/Urinary Problems	☐ Diabetes	☐ Tuberculosis/TB
☐ Eczema	☐ Seizures	☐ Pneumonia	☐ Tobacco Use
☐ Migraines	☐ Glasses/Contacts	☐ Kidney/Renal Disease	☐ Substance/Drug Abuse
☐ Premature Birth	☐ Hearing Aids	☐ Heart Problem	☐ Past or Current Elevated Lead Level
☐ Sickle Cell	☐ Mental Health Concerns	☐ Developmental Problems	

☐ Other (Please explain): _____

Student Name: _____ **Student DOB:** _____

Primary Care Provider Information

Name of Primary Care Provider/Physician (PCP): _____

PCP Location (please check):
- ☐ Care Alliance
- ☐ Cleveland Clinic
- ☐ MetroHealth
- ☐ Neighborhood Family Practice
- ☐ NEON
- ☐ UH/Rainbow Babies and Children
- ☐ Other: _____

Preferred Retail Pharmacy

Name: _____ Address: _____ Phone Number: _____

Patient/Student Allergies

☐ **NO KNOWN ALLERGIES**

☐ **YES**—Please list below:

Food: _____

Medications: _____

Insects: _____

Seasonal: _____

Animals: _____

Immunization History

Has your child every had a reaction to any immunizations/shots?

☐ Yes ☐ No

If YES, please explain reaction _____

What immunization/shot caused reaction: _____

Services: Additional school-based health services may include the following services unless you tell us not to.

Cross out any services you DO NOT want your child to receive.

- Physical exams (well-child, sports, work)
- Care and treatment for injury/illness
- Medication administration (albuterol, epinephrine, antibiotics, prescription and over-the-counter medications)
- Routine lab tests
- Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- Mental/behavioral health assessment, screening, and intervention (additional parental/guardian consent required for children under the age of 18)
- Drug or alcohol use treatment
- Sexual wellness services
- Vision and hearing screening and treatment
- Lead testing/screening
- COVID-19 testing/screening
- Dental screening and services (dental x-rays, sealants, and cleanings; therapeutic fillings, fluoride applications)
- Health education and prevention programs
- Sports medicine services

Immunizations (shots): Your school nurse and the School Health Program team will review your child's record to determine which shots are needed.

Cross out any shots you DO NOT want your child to receive.

School-Required Immunizations:

- DTap/Td (diphtheria, tetanus, and whooping cough for children)
- Tdap (tetanus, diptheria, and whooping cough for adolescents)
- Polio
- Hepatitis B
- MMR (Measles, Mumps, Rubella)
- Meningococcal A
- Varicella (Chicken Pox)

Pediatric/Adolescent Recommended Immunizations:

- Human Papillomavirus (HPV)
- Influenza (Flu)
- Hepatitis A
- Meningococcal B
- COVID-19 Vaccine

Please visit **http://www.immunize.org/vis/** to find the Vaccine Information Statement for each vaccine, which will explain risks and benefits of all vaccines.

[1]Throughout this form the term "Parent/Guardian" means all of the following groups: parents/custodians/emancipated minors signing on their own behalf.

Student Name: _____ **Student DOB:** _____

Consent for Health Services/Treatment

By signing below, I consent for my child to receive the additional School-Based Health Services (the "Services") listed below when necessary to promote my child's health. I understand that these Services will be performed by a health provider in partnership with CMSD and that contact information for all partner health providers can be found on CMSD's website at https://www.clevelandmetroschools.org/Page/19754. I also understand that examination and treatment may be in-person or by telehealth. Treatment received using telehealth does not allow for direct contact with a patient and may be affected by transmission quality. If I no longer want my child to receive any of the Services, I may request that they be stopped, and that request will not affect my ability to obtain medical care for my child in the future.

Agreement of Financial Responsibility

Insurance or other health care coverage programs are billed whenever possible to help cover the cost of care. If applicable, I agree to provide complete, accurate, and timely information relating to any available health insurance in order for CMSD partner providers to seek payment in a timely manner. These Services are provided to students whether or not a student has insurance or the ability to pay. I give CMSD partner providers the right to submit claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which a benefit may be available to pay for Services provided to my child. I have read and understand the information about additional School-Based Health Services available through CMSD partner health providers. My signature provides consent for my child to receive the Services for as long as my child is a student in CMSD. I understand that I can revoke my consent at any time by providing a written request to CMSD.

Signature of Parent/Legal Guardian (or student if 18 years or older or otherwise permitted by law):

_____

Print Name of Parent/Legal Guardian:

_____

Relationship to the Child/Student:

_____

Date: _____

Authorization to Release Health Information

I authorize CMSD partner health providers to provide my child's medical information, including diagnosis, treatment records, vaccinations, and lab results, to CMSD school officials, including SYC staff and third parties, engaged in the facilitation of CMSD's student health and wellness initiatives, for treatment, referral, and/or care coordination. I authorize CMSD and SYC to provide a copy of medical information or other relevant personal information within my child's school records to CMSD partner health providers. I agree to allow CMSD partner health providers to access my child's individual academic, attendance, and behavior records for the current and prior school years so they can provide better services to my child.

I understand that my express consent (or in some cases, my child's express consent) may be required for the disclosure of certain diagnosis and treatment information relating to sexually transmitted diseases, AIDS, HIV, mental illness, psychiatric treatment, and/or drug or alcohol use treatment. CMSD partner health providers may only disclose information relating to such diagnosis, testing, or treatment as directed in this authorization and as allowed under applicable law.

I understand that I am not required to sign this authorization, that I do so of my own free will, and that if I refuse to sign this authorization to disclose my child's information, it will not in any way prevent my child from receiving care or treatment from any of the providers listed. I understand that I may terminate this authorization in writing at any time, prior to the release of my child's information, though such termination would not impact information released prior to the submission of a written termination notice. I am also aware there is potential for information disclosed under this consent to be redisclosed by the recipient and no longer be protected.

Notice of Privacy Practices Acknowledgement

I have been notified that I can ask for a copy of the Notice of Privacy Practices forms for CMSD partner health providers. I know that I can also view them online at https://www.clevelandmetroschools.org/Page/19754. I understand that the terms of the Privacy Notice may change and I may get these changed notices by contacting CMSD partner health providers by phone or in writing. I understand I have the right to ask how my protected health information will be used or given out. I CERTIFY THAT I HAVE READ THIS AUTHORIZATION TO RELEASE HEALTH INFORMATION AND CONSENT TO THE RELEASE OF MY CHILD'S INFORMATION AS DESCRIBED ABOVE. I FURTHER ACKNOWLEDGE THAT I HAVE RECEIVED INFORMATION ABOUT HOW TO RECEIVE NOTICE OF PRIVACY PRACTICES AS EXPLAINED IN THIS DOCUMENT. THIS AUTHORIZATION FORM WILL REMAIN VALID WHILE MY CHILD IS ENROLLED IN CMSD OR UNTIL I TERMINATE IT IN WRITING.

Signature of Parent/Legal Guardian:

_____

Print Name of Parent/Legal Guardian:

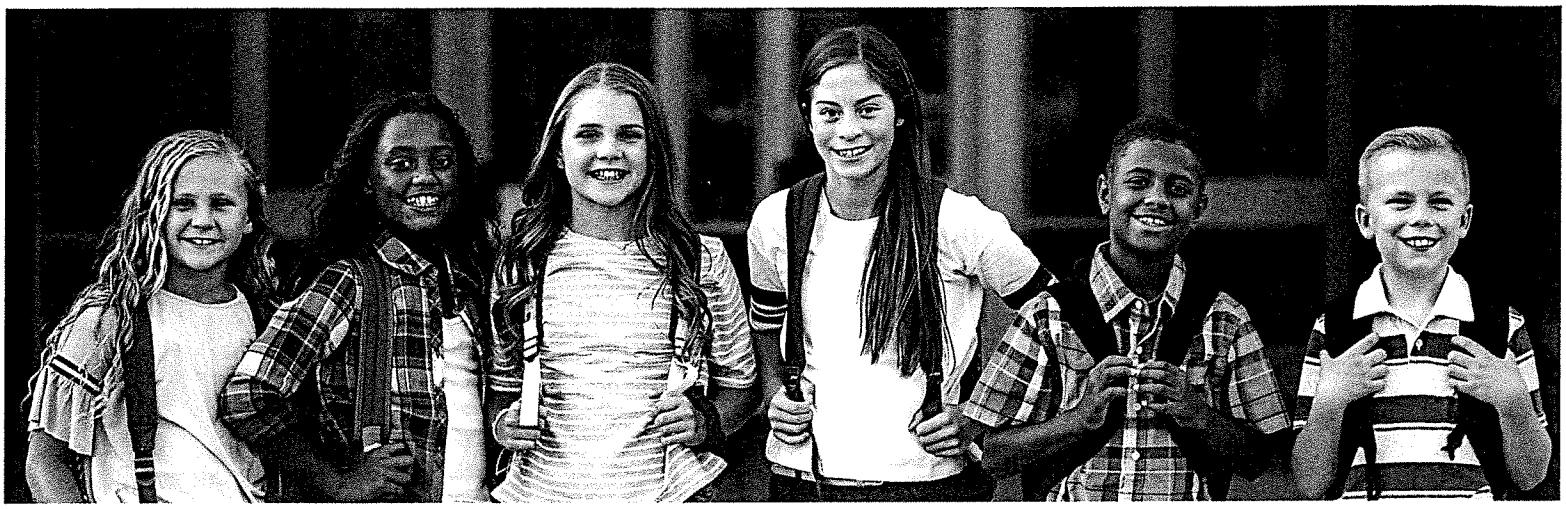
_____

Relationship to the Child/Student:

_____

Date: _____

Institute for H.O.P.E.™ MetroHealth



AT-SCHOOL HEALTH CARE

Now available for your child!

Our school district is now offering convenient on-site health care to students. If your child is not feeling well, has a chronic medical issue or injury or is due for their annual physical and vaccinations, they can easily receive medical care from MetroHealth providers at school, during their school day, through the Institute for H.O.P.E. School Health Program.

Available Services

- Annual physicals
- Sports physicals
- Injury/illness care
- Routine lab tests
- Prescription medications
- Teen services
- Immunizations
- Mental/behavioral health
- Care for chronic conditions, including asthma, allergies, diabetes and seizure disorders
- Health education and prevention
- Telehealth, to supplement in-person care
- Contact the School Health Program for questions about any additional services that may be available at our school

To Make an Appointment

- Call **216-957-1303** or contact your school nurse.
- Check metrohealth.org/ school-health website for our clinic schedule, same-day appointments may be available.

Institute for H.O.P.E.™ MetroHealth

Frequently Asked Questions

What are the benefits for my family?

Being on-site improves access to care. Families do not have to worry about transportation or cost. Students do not have to miss school for an appointment and parents do not have to miss work. Students receive care and quickly return to the classroom to continue learning.

Who provides care at the clinic?

Your child will receive care from a multidisciplinary team of experienced MetroHealth providers. This team may include doctors, nurse practitioners, nurses, behavioral health specialists and medical assistants. The Institute for H.O.P.E. School Health Program brings the expertise and community dedication of an extensive health system into our school.

What if my child already has a doctor?

Our School Health Program team can partner with your doctor to support your child's health. Our team has experience working closely with primary health care partners and specialists. Your child will also receive an After Visit Summary explaining the care they received, which is also accessible online via MyChart.

How much does a clinic visit cost?

The School Health Program will bill private insurance and/or Medicaid when able.

What if I don't have health insurance?

Our team can also help connect your child with insurance resources.

Do students need parent permission to visit the clinic?

Yes. Parents or legal guardians must sign a consent form prior to a child receiving care. The consent form can be found at metrohealth.org/school-health and returned to your school nurse.

To learn more, contact:
Telephone: 216-957-1303
Email: schoolhealth@metrohealth.org
Website: metrohealth.org/school-health

To make an appointment:
Call the School Health Program at 216-957-1303 or talk to your school nurse.