Jefferson County Public Schools Health Services *JCPS Student ID #:*_____

Primary Care Provider Authorization (PCP): Asthma/Allergy (Side One)

2014-2015 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

Does this child have ASTHMA? ____ YES ____ NO

What things may bring on this child's asthma?
__ Pollens __ Dust __ Animals __ Exercise __ Foods
__ Illness __ Other_____

Asthma SYMPTOMS may include: Coughing, Shortness of Breath, and Wheezing. Please list any other symptoms specific for this child:
_____

***Please refer to Emergency Plan of Action on Side Two for symptoms indicating an emergency asthma situation.**

Asthma Medications AT SCHOOL:
Order will be for current school year unless otherwise indicated.

__ Albuterol (Ventolin, Proventil, ProAir), Xopenex, Maxair (Circle)
- __ 2 puffs every 4-6 hours as needed
- __ _____ puffs every _____ hours as needed
- __ 2 puffs _____ minutes prior to exercise
- __ Nebulizer every 4-6 hours as needed_____

__ Other medication _____
Instructions _____

***If student needs inhaler more than twice a week, please notify parent.**

Is this student trained and capable of carrying their own inhaler and using it on their own? ___ YES ___ NO

If student not carrying inhaler, it is to be kept:
__ In front office or student classroom
__ Other _____

Please complete both sides of this form. Form MUST be signed by Health Care Provider AND Parent/Guardian.

Does this child have ALLERGIC REACTIONS? __ YES __ NO
What things cause this student's allergic reaction? Please list.
__ Medications _____
__ Stinging Insects _____
__ Other _____

FOOD ALLERGY? __ YES __ NO
Please list any food allergies: _____
Any food not to be served to student: _____
Please list alternative foods for student:_____
Is student Lactose Intolerant? __ YES __ NO

Nutritional info available at www.jefferson.ky12.ky.us/Departments/NutritionServices or you may call 485-3186 for more information.

SYMPTOMS of the allergic reaction for this child:
__Itching/Swelling of Lips, Mouth, Tongue or Throat
__Hives/Rash __Nausea/Vomiting/Stomach Cramps
__Shortness of Breath __Wheezing __Coughing
__Dizziness __Unconsciousness __ Other _____

Medications AT SCHOOL:
Order will be for current school year unless otherwise indicated.
__ EpiPen Jr. __ EpiPen __ Twinject __Auvi-Q

___ Give Epipen/Twinject/ Auvi-Q at onset of allergic reaction and/or exposure to allergy trigger.
___ Other instructions_____

***IF 2nd DOSE OF TWINJECT OR 2nd EPIPEN/ Auvi-Q NEEDED, give:**
____ Minutes after 1st Dose
Other medications: _____

May student carry own EpiPen/Twinject and use on their own?
__ YES __ NO
If student not carrying EpiPen/Twinject, it is to be kept:
__ In front office or student classroom __Other _____

	Initials/Date
Reviewed by Health Services	_____
Entered by Health Services	_____
School received/sent to Health Services and School Staff	_____

Jefferson County Public Schools Health Services ***JCPS Student ID#:*** _____

Primary Care Provider Authorization (PCP): Asthma/Allergy (Side Two)

2014-2015 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

EMERGENCY PLAN OF ACTION

1. Follow orders on page 1 for Asthma and/or Allergy treatments and medications.
2. If student is hunched over and/or having difficulty breathing, walking or talking, blue fingernails or lips, peak flow meter reading in red zone and/or medications not helping, call EMS 9-911.
3. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian.
5. If EMS is called, the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
6. If student requires medical treatment while on the bus, the bus driver will contact EMS.
7. Other:

FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN

_____ _____ _____

Printed Name of MD, APRN, or PA Address

_____ _____ _____

Signature of MD, APRN, or PA Date

Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed JCPS personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip, this medication and/or health service may also be administered by a licensed volunteer. By signing this form, the parent/guardian shall acknowledge that the Jefferson County Board of Education and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of his/her medications to treat asthma or anaphylaxis and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to self-administration of school medication. This form shall not relieve the liability of the school or its employees for their own negligence. I hereby give permission for the health care provider completing and signing this form to verify this information with JCPS and consult with JCPS staff regarding this information.

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

****Parent/Guardian signature required only for INITIAL 2014-2015 PCP form. Parent/Guardian signature not required for updated 2014-2015 PCP form.**

_____ _____ _____

Emergency Contact Telephone No. Relationship

PLEASE RETURN THIS COMPLETED FORM TO:

Jefferson County Public Schools - Health Services Department

Lam Building, 4309 Bishop Lane, Louisville, KY 40218 Telephone No. (502) 485-3387 Fax: (502) 485-3670

FINAL April 22, 2014