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

Primary Care Provider (PCP) Authorization: Other Health Conditic (Side One)

2014-2015 School Year

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

DIAGNOSIS:

- ☐ Sickle Cell Anemia
- ☐ Cystic Fibrosis
- ☐ Long QT Syndrome
- ☐ Hemophilia
- ☐ Hypertension
- ☐ OTHER (SPECIFY): _____
- ☐ ADHD/ADD
- ☐ Autism
- ☐ Ostomy Type: _____
- ☐ Spina Bifida
- ☐ Fainting Spells
- ☐ VP Shunt

Latex Allergy ☐ Yes ☐ No

PRECAUTIONS AT SCHOOL: _____

_____

_____

RESTRICTIONS/EXCLUSIONS AT SCHOOL: _____

_____

_____

OTHER COMMENTS: _____

_____

_____

Nutritional information is available at
www.jefferson.k12.ky.us/Departments/NutritionServices
or you may call 3186 for information.

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

Oral/Nasal Suctioning (Je one)

***All supplies and equipat are to be provided by the parent/guardian.**

Suctioning Insttions:

- ☐ Oral Suction
- ☐ Nasal Suctioning
- ☐ Yanker/Soft catheter
- ☐ Saline Instillation needed
- ☐ Other (Expla _____

Suctioning Frecicy

- ☐ Every _____ minutes
- ☐ Every _____ hours
- ☐ As needed ba upon signs and symptoms as follows:
  - ☐ Cho/Continuous coughing/Gurgling
  - ☐ Upcudent's request
  - ☐ Othspecify): _____

Urinary Catheterizatio ☐ **Urethral** ☐ **Suprapubic**

***All supplies and equipit are to be provided by the parent/guardian.**

Times for procedure (Be cific): _____ _____ _____ _____

Recommended position:

_____

If questions regarding catrization times, may we contact the parent/guardian for decision? ☐ Yes ☐ No

Can this student catheteri im or herself?

☐ **Yes** ___Indedently ___Adult Assistance ☐ **No**

Check the typical charactcics of student's urine:

- ☐ Clear
- ☐ Cloudy
- ☐ Odor
- ☐ Typically has blood in
- ☐ Typical colord amount of output:

_____

*** Please note: When anyanges in the student's typical characteristics are observed, THE PAREN-UARDIAN MUST BE NOTIFIED IMMEDIATELY.**

	Initials/Date
Reviewed by Hea ervices	_____
Entered by Healh vices	_____
School received/s Health Services and School Staff	_____

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

Primary Care Provider (PCP) Authorization: Other Health Conditions (Side Two)

2014-2015 School Year

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

EMERGENCY PLAN OF ACTION

1. **If student's color becomes pale, cyanotic (bluish), or ashen OR student has other signs of respiratory distress (difficulty breathing, gasping, etc.), call EMS 9-911.**
2. **Notify school personnel trained in CPR/first aid to stay with student and initiate CPR if needed prior to EMS arrival.**
3. **Contact parent/guardian immediately.**
4. **If EMS is called student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and parent/guardian then assumes responsibility for student. Student may not return to school that day.**
5. **When student is transported via EMS a JCPS staff member must ride with student unless parent and/or emergency contact accompanies them.**
6. **If a student requires medical treatment while on the bus, the driver will contact EMS.**
7. **Other:** _____

Form must be signed by health care provider and parent/guardian. If you have any questions please call (502) 485-3387 or Fax: (502) 485-3670.

Please return to:

Jefferson County Public Schools
Health Services
Lam Building
4309 Bishop Lane
Louisville, KY 40218

Printed Name MD, APRN or PA _____ Address _____ Signature of MD, APRN, or PA _____

I hereby acknowledge 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 may also be administered by a licensed volunteer. By signing this form, the parent/guardian acknowledges that the Jefferson County Board of Education, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent/guardian shall hold harmless the school and its employees against any claims made for any reaction to any medication or the administration of such medication unless the reaction is due to negligence or misconduct on behalf of the school or its employees. Also, I hereby give permission for the health care provider completing and signing this form to verify this information with JCPS and to 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 _____ Final April 22, 2014