

Jefferson County Public Schools Health Services
Primary Care Provider Authorization (PCP): Asthma/Allergy (Side One)
2012-2013 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, etc)

2 puffs every 4-6 hours as needed

2 puffs _____ minutes prior to exercise

Other _____

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 _____

Does this child have ALLERGIC REACTIONS? YES NO

What things cause this student's allergic reaction?

Medications _____

Stinging Insects _____

Other _____

FOOD ALLERGY? YES NO

Please list any food allergies: _____

Any food not to be served to 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

Give EpiPen/Twinject at onset of allergic reaction and/or exposure to allergy trigger.

Other instructions _____

***IF 2nd DOSE OF TWINJECT OR 2nd EPIPEN 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	_____

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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 Telephone No.

Signature of MD, APRN, or PA Date Fax Number

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 2012-2013 PCP form. Parent/Guardian signature not required for updated 2012-2013 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