# Jefferson County Public Schools Health Services

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

**2012-2013 School Year**

**Student Name: ___________________________Date of Birth: _________________School: ______________________________**

## DIAGNOSIS:

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

**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 (circle one)**

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

**Suctioning Instructions:**

- ☐ Oral Suctioning
- ☐ Nasal Suctioning
- ☐ Yanker/Soft tip catheter
- ☐ Saline Instillation needed
- ☐ Other (Explain): ______________________________

**Suctioning Frequency**

- ☐ Every _______ minutes ☐ Every ______ hours
- ☐ As needed based upon signs and symptoms as follows:
  - ☐ Choking/Continuous coughing/Gurgling
  - ☐ Upon student's request
  - ☐ Other (Specify): ______________________

**Urinary Catheterization** ☐ **Urethral** ☐ **Suprapubic**

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

Times for procedure (Be Specific): ______ ______ ______ ______

Recommended position:

_______________________________________________

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

Can this student catheterize him or herself?

☐ **Yes** ___Independently ___Adult Assistance ☐ **No**

Check the typical characteristics of student's urine:

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

________________________________________

*** Please note: When any changes in the student's typical characteristics are observed, THE PARENT/GUARDIAN MUST BE NOTIFIED IMMEDIATELY.**

| Initials/Date | |
|---|---|
| Reviewed by Health Services | ___________ |
| Entered by Health Services | ___________ |
| School received/sent to Health Services | ___________ |

**Jefferson County Public Schools Health Services**

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

**2012-2013 School Year**

**Student Name: ______________________Date of Birth: ___________School: ____________________________**

**<u>EMERGENCY PLAN OF ACTION</u>**

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**<br>**Health Services**<br>**Lam Building**<br>**4309 Bishop Lane**<br>**Louisville, KY 40218**

| ______________________ | ______________________ | ________________ | ______________________ |
|---|---|---|---|
| Printed Name MD, ARNP or PA | Address | Telephone No./Fax No. | Signature of MD, ARNP, 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 | |
| ______________________ | ______________ | ____________ | |
| Emergency Contact | Telephone No. | Relationship | Revised June 6, 2012 |