Return completed form to:
Jefferson County Public Schools,
Health Services Department, LAM Building
4309 Bishop Lane, Louisville, KY 40218
Telephone # (502) 485-3387
Fax # (502) 485-3670

JEFFERSON COUNTY PUBLIC SCHOOL
SCHOOL HEALTH PLAN
ASTHMA

School Year:

DO NOT WRITE IN THIS AREA
0770620686

Please print neatly. Por favor, escriba legible

PART A Parent / Guardian: Complete Items 1 - 11 *(Padre/madre/tutor: complete la información en los espacios 1 al 11)*

1) Student ID# *(Numero de estudiante)* | **2) Student's Last Name** *(Apellido)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

5) School *(Escuela)* | **6) Grade** *(Grado)*

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

7) Name *(Nombre)* | **8)** Phone Number *(Teléfono)* ( ) - | **9)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

10) Emergency Contact (Contacto de emergencia y Teléfono) ( ) -

11) Note to parent/guardian: Signing this form shall release the Jefferson County Board of Education and its employees from liability of any nature that might result from this plan of action. This form shall not relieve the liability of the school or its employees for their own negligence. Also, I hereby give permission for the healthcare provider completing and signing this form to verify this information with JCPS staff regarding this information. I also acknowledge that medications and treatments will most likely be administered by trained, unlicensed JCPS personnel. I acknowledge and agree when I authorize by child to attend a school sponsored field trip these medications and/or health services may also be provided by a licensed volunteer.
Parents please note: A prescription authorization form must be on file at school for medications to be given at school

PARENT/GUARDIAN Signature X | **TELEPHONE NUMBER** ( ) - | **DATE**

PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 17
(12 al 17 - Esta sección para ser completada por el médico solamente.)

12) Does this child have ASTHMA? ☐ **YES** ☐ **NO** **Other Diagnosis:** _____

13) What things may bring on this child's asthma?
☐ Pollens ☐ Dust ☐ Animals ☐ Exercise ☐ Foods ☐ Illness ☐ Other:_____

14) Asthma SYMPTOMS may include:
☐ Coughing ☐ Wheezing ☐ Shortness of breath
☐ Please list any other symptoms specific for this child: _____
_____

15) Asthma Medications AT SCHOOL: ☐ **YES** ☐ **NO**

16) Is this student trained and capable of carrying their own inhaler and using it on their own? ☐ **YES** ☐ **NO**

17) Healthcare Provider Information Form **must** be signed by a Healthcare Provider **and** parent/guardian
Healthcare Provider Signature X | Date
Healthcare Provider Printed Name
Medical Office Stamp (required for processing)