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 SCHOOLS
SCHOOL HEALTH PLAN
ASTHMA ACTION PLAN

School Year:

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: In order for medications to be administered, parent must complete an "Authorization for Medication" form for each medication needed at school.

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

PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 18
(12 al 18 - Esta sección para ser completada por el médico solamente.)

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

13) Asthma Severity:

☐ Intermittent ☐ Mild Persistent ☐ Moderate persistent ☐ Severe persistent ☐ He/she has had many or severe asthma attacks/exacerbations

14) What things may bring on this child's asthma?

☐ Pollens ☐ Dust ☐ Animals ☐ Exercise ☐ Foods ☐ Illness ☐ Other:_____

15) Asthma SYMPTOMS may include:

☐ Coughing ☐ Wheezing ☐ Shortness of breath

☐ Please list any other symptoms specific for this child: _____

_____

16) Asthma Medications AT SCHOOL: ☐ YES ☐ NO

17) Both the asthma provider and the parent/guardian feel that the student may carry and self administer their inhalers. ☐ YES ☐ NO

18) **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)

This institution is an equal opportunity provider and employer.