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
NON-FOOD ALLERGIES

Please print neatly. Por favor, escriba legible

School Year:

DO NOT WRITE IN THIS AREA
7906315012

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 exchange information with JCPS staff regarding this health condition. I acknowledge and agree when I authorize my 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 – 16
(12 al 16 - Esta sección para ser completada por el médico solamente.)

12) Please list allergies.

- ☐ Medications: _____
- ☐ Stinging Insects: _____
- ☐ Other: _____

13) Allergic reaction symptoms may include:
Itching/Swelling of Lips, Mouth, Tongue or Throat, Hives/Rash, Nausea/Vomiting/Stomach Cramps, Shortness of Air, Wheezing, Coughing, Dizziness, Unconsciousness

Please list any other symptoms specific for this child: _____

14) Medications at School:

☐ Epipen Jr. ☐ Epipen ☐ Auvi-Q

* EpiPen/Twinject/Auvi-Q to be given at onset of allergic reaction and/or exposure to allergy trigger.

15) May student carry own EpiPen/Auvi-Q device and use on their own?

☐ Yes ☐ No

16) 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.