



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

NON-FOOD ALLERGIES

School Year:

DO NOT WRITE IN THIS AREA
 3840443422

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

PARENT/GUARDIAN Signature

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) Device at School:

Name of Epinephrine device at school: _____ Epinephrine device not needed at school

* Epinephrine device to be given at onset of allergic reaction and/or exposure to allergy trigger.

15) May student carry own Epinephrine 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

Date

Healthcare Provider Printed Name

Medical Office Stamp (required for processing)