

Jefferson County Public Schools Health Services  
PCP Form/School Health Plan: Asthma/Allergy (Side One)  
School Year: \_\_\_\_\_

JCPS Student ID# \_\_\_\_\_

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_

**Does this child have ASTHMA?**  YES  NO

**Other Diagnosis:** \_\_\_\_\_

**What things may bring on this child's asthma?**

- Pollens  Dust  Animals  Exercise  Foods  Illness  
 Other \_\_\_\_\_

**Asthma SYMPTOMS may include:**

Coughing · Shortness of Breath · Wheezing

**Please list any other symptoms specific for this child:**  
\_\_\_\_\_

**Asthma Medications AT SCHOOL:**

**Albuterol (Ventolin, Proventil, ProAir), Xopenex, Maxair (Circle)**

- 2 puffs every 4-6 hours as needed  
 \_\_\_\_\_ puffs every \_\_\_\_\_ hours as needed  
 2 puffs \_\_\_\_\_ minutes prior to exercise  
 Nebulizer every 4-6 hours as needed \_\_\_\_\_

**Other medications:** \_\_\_\_\_

**Instructions:** \_\_\_\_\_

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

**EMERGENCY PLAN OF ACTION**

- Follow orders on page 1 & 2 for Allergy and/or Asthma treatments and medications.
- If student is hunched over and/or having difficulty breathing, walking or talking, blue fingernails or lips, peak flow meter reading in red zone and/or medications not helping, call EMS 911.
- Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
- Notify parent/guardian.
- If EMS is called, the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
- If student requires medical treatment while on the bus, the bus driver will contact EMS.
- Other: \_\_\_\_\_  
\_\_\_\_\_

**Does this child have NON-FOOD RELATED ANAPHYLACTIC ALLERGIC REACTIONS?**  YES  NO

**\*\*\*FOR FOOD RELATED ALLERGIES, COMPLETE SIDE TWO\*\*\***

**Please list allergies.**

- Medications: \_\_\_\_\_  
 Stinging Insects: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Allergic Reaction SYMPTOMS may include:**

Itching/Swelling of Lips, Mouth, Tongue or Throat · Hives/Rash ·  
Nausea/Vomiting/Stomach Cramps · Shortness of Breath · Wheezing · Coughing ·  
Dizziness · Unconsciousness

**Please list any other symptoms specific for this child:**  
\_\_\_\_\_

**Medications AT SCHOOL:**

- EpiPen Jr.  EpiPen  Twinject  Auvi-Q

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

**\*\*\*IF 2<sup>nd</sup> DOSE OF Twinject OR 2<sup>nd</sup> EpiPen/Auvi-Q NEEDED give:**

\_\_\_\_\_ Minutes after 1<sup>st</sup> Dose

**May student carry own EpiPen/Twinject/Auvi-Q and use on their own?**

- YES  NO  
 **Other medications:** \_\_\_\_\_

**THIS FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN.**

Reviewed by Health Services  
Entered by Health Services  
School received/sent to Health Services & School Staff

Initials/Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Jefferson County Public Schools Health Services  
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School Year: \_\_\_\_\_

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School: \_\_\_\_\_

**Does this child have a FOOD RELATED ANAPHYLACTIC FOOD ALLERGY?**

YES  NO

Please list: \_\_\_\_\_

**Foods to OMIT:** \_\_\_\_\_

**Foods to Substitute:** \_\_\_\_\_

**Allergic Reaction SYMPTOMS may include:**

Itching/Swelling of Lips, Mouth, Tongue or Throat · Hives/Rash ·  
Nausea/Vomiting/Stomach Cramps · Shortness of Breath · Wheezing · Coughing ·  
Dizziness · Unconsciousness

**Please list any other symptoms specific for this child:**

\_\_\_\_\_

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\_\_\_\_\_ Minutes after 1<sup>st</sup> Dose

**May student carry own EpiPen/Twinject/Auvi-Q and use on their own?**

YES  NO

**Other medications:** \_\_\_\_\_

Nutritional information available at  
[www.jefferson.ky12.ky.us/Departments/NutritionServices](http://www.jefferson.ky12.ky.us/Departments/NutritionServices)

**Does this child have a non-life threatening FOOD ALLERGY?**

YES  NO

Please list: \_\_\_\_\_

**Does this child have a FOOD/DAIRY INTOLERANCE?**  YES  NO

Please list: \_\_\_\_\_

**Food(s) to OMIT (Check all that apply):**

**DAIRY:**  Fluid Milk  Cheese  Yogurt

Recipes with milk or milk products listed as an ingredient

**EGG:**  Whole Eggs (Scrambled Eggs)

Recipes with any egg listed as an ingredient

**WHEAT:**  Recipes with any wheat listed as an ingredient

**FISH or SHELLFISH:**

Specific fish or seafood type: \_\_\_\_\_

**NUTS:**  Peanuts  Tree Nuts

**CORN:**  Whole corn (Corn Kernel, Tortilla Chips, Corn Muffin)

Recipes with corn listed as an ingredient (Corn Syrup, Corn Starch, etc)

**OTHER:** \_\_\_\_\_

**Food(s) to substitute:**

**DAIRY:**  Lactose Free

Soy Milk

**OTHER:** \_\_\_\_\_

Printed Name of MD, APRN, or PA

Signature of MD, APRN, or PA

Address

Telephone # /Fax #

Date

\*Parent/guardian hereby acknowledges 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 and/or health service may also be administered by a licensed volunteer. By signing this form, the parent/guardian shall acknowledge that the Jefferson County Board of Education and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of his/her medications to treat asthma or anaphylaxis and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to self-administration of school medication. This form shall not relieve the liability of the school or its employees for their own negligence. I hereby give permission for the health care provider completing and signing this form to verify this information with JCPS and consult with JCPS staff regarding this information.

Signature of Parent/Guardian

Telephone #

Date

\*\*Parent/Guardian signature required only for INITIAL health form for current school year.

Emergency Contact

Telephone #

Relationship

Were you charged a separate fee to have this form completed?

Yes

No

**Please return to:** Jefferson County Public Schools Health Services Department, Lam Building,  
4309 Bishop Lane, Louisville, KY 40218  
Telephone # (502) 485-3387 Fax # (502) 485-3670

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