

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

1. Follow orders on page 1 & 2 for Allergy and/or Asthma treatments and medications.
2. 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.
3. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian.
5. 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.
6. If student requires medical treatment while on the bus, the bus driver will contact EMS.
7. 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 2nd DOSE OF Twinject OR 2nd EpiPen/Auvi-Q NEEDED give:**

_____ Minutes after 1st 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
PCP Form/School Health Plan: Allergy/Asthma (Side Two)
School Year: _____

JCPS Student ID# _____

Student Name: _____ **Date of Birth:** _____

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

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_____ Minutes after 1st 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

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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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