



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 Other Health Conditions

School Year:

DO NOT WRITE IN THIS AREA
 8277001881

*****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)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

5) School (Escuela)	6) Grade (Grado)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

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)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

10) Emergency Contact (Contacto de emergencia y Teléfono)

<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>
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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
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>

PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 - 17 (12 al 17 - Esta sección para ser completada por el médico solamente.)

12) Student Diagnosis:

<input type="checkbox"/> ADHD ICD 10 code: _____	<input type="checkbox"/> Headaches ICD 10 code: _____	<input type="checkbox"/> Urinary System Abnormalities ICD 10 code: _____
<input type="checkbox"/> Autism ICD 10 code: _____	<input type="checkbox"/> Heart Condition ICD 10 code: _____	<input type="checkbox"/> Other (1) DX: _____ Code: _____
<input type="checkbox"/> Bleeding/Clotting Disorder ICD 10 code: _____	<input type="checkbox"/> Psychiatric Condition ICD 10 code: _____	(2) DX: _____ Code: _____
<input type="checkbox"/> CP ICD 10 code: _____	<input type="checkbox"/> Neurological Disorder ICD 10 code: _____	(3) DX: _____ Code: _____

13) Precautions/Restrictions at school:

14) Is suctioning needed at school? YES, please complete below No

Type _____ Instructions: _____

Frequency? _____

15) Is catheterization needed at school? YES, please complete below No

Type _____

Frequency? _____

16) Additional Health Care Provider's Comments:

17) Healthcare Provider Information Form must be signed by a Healthcare Provider and parent/guardian

Healthcare Provider Signature	Date	Medical Office Stamp (required for processing)
<input style="width:100%;" type="text"/>	<input style="width:100%;" type="text"/>	<input style="width:100%; height: 100%;" type="text"/>
Healthcare Provider Printed Name	<input style="width:100%;" type="text"/>	