

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

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

DOES THIS STUDENT HAVE A DISABILITY?  Yes  No

**DIAGNOSIS:**

- Sickle Cell Anemia
- Cystic Fibrosis
- Long QT Syndrome
- Hemophilia
- Hypertension
- Vasomotor Instability
- Celiac Disease
- Migraine
- ADHD/ADD
- Autism
- Ostomy Type: \_\_\_\_\_
- Spina Bifida
- Fainting Spells
- VP Shunt
- Cerebral Palsy
- Other \_\_\_\_\_

Latex Allergy/Sensitivity:  Yes  No

**MAJOR LIFE ACTIVITIES AFFECTED BY THE ABOVE DISABILITY:**

- Eating
- Learning
- Behavior
- Digestion
- Swallowing
- Activities of Daily Living
- Other: \_\_\_\_\_

**PRECAUTIONS AT SCHOOL:** \_\_\_\_\_

**RESTRICTIONS/EXCLUSIONS AT SCHOOL:** \_\_\_\_\_

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

**IF MEAL ACCOMODATIONS ARE REQUIRED:**

Foods to omit: \_\_\_\_\_  
Foods to substitute: \_\_\_\_\_

Nutritional information is available at  
[www.jefferson.k12.ky.us/Departments/NutritionServices](http://www.jefferson.k12.ky.us/Departments/NutritionServices)

**Oral/Nasal Suctioning (circle one)**

**\*All supplies and equipment are to be provided by the parent/guardian.**

Suctioning Instructions:

- Oral Suctioning
- Yanker/Soft tip catheter
- Other (Explain): \_\_\_\_\_
- Nasal Suctioning
- Saline Instillation needed

Suctioning Frequency

- Every \_\_\_\_\_ minutes
- Every \_\_\_\_\_ hours
- As needed based upon signs and symptoms as follows:
  - Choking/Continuous coughing/Gurgling
  - Upon student's request
  - Other (Specify): \_\_\_\_\_

**Urinary Catheterization**  Urethral  Suprapubic

**\*All supplies and equipment are to be provided by the parent/guardian.**

Times for procedure (Be Specific): \_\_\_\_\_  
Recommended position: \_\_\_\_\_

If questions regarding catheterization times, may we contact the parent/guardian for decision?  Yes  No

Can this student catheterize him or herself?

- Yes  Independently  Adult Assistance  No

Check the typical characteristics of student's urine:

- Clear
- Cloudy
- Odor
- Typically has blood in
- Typical color and amount of output:

**\* Please note: When any changes in the student's typical characteristics are observed, THE PARENT/GUARDIAN MUST BE NOTIFIED IMMEDIATELY.**

**Please complete both sides of this form. Form MUST be signed by Health Care Provider AND Parent/Guardian.**

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

**Jefferson County Public Schools Health Services**  
**PCP Form/School Health Plan: Other Health Conditions (Side Two)**  
**School Year: \_\_\_\_\_**

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

**EMERGENCY PLAN OF ACTION**

1. If student's color becomes pale, cyanotic (bluish), or ashen OR student has other signs of respiratory distress (difficulty breathing, gasping, etc.), call EMS 911.
2. Notify school personnel trained in CPR/first aid to stay with student and initiate CPR if needed prior to EMS arrival.
3. Contact parent/guardian immediately.
4. If EMS is called, student must be transported via EMS to the emergency facility unless parent/guardian signs release with EMS. Parent/guardian then assumes responsibility for student. The student may not return to school that day.
5. When student is transported via EMS, a JCPS staff member must ride with student unless parent and/or emergency contact accompanies them.
6. If a student requires medical treatment while on the bus, the driver will contact EMS.
7. Other: \_\_\_\_\_

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

\_\_\_\_\_  
 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
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**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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