JCPS Student ID # _____

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

Oral/Nasal Suctioning (circle one)

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

Suctioning Instructions:

☐ Oral Suctioning ☐ Nasal Suctioning
☐ Yanker/Soft tip catheter ☐ Saline Instillation needed
☐ Other (Explain): _____

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.

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

JCPS Student ID # _____

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?

☐ 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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Offering Equal Educational Opportunities

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