

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 SCHOOL ding SCHOOL HEALTH PLAN Other Health Conditions

School	Year:

7229270953

Conditions 7229

	Fax # (502) 485-367	70 ***Please print n	eatly. Por favor, escriba legible***
PA	RT A Parent / Guardian:	Complete Items 1 - 11 (Padre/m	nadre/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)
5)	School (Escuela)		6) Grade (Grado)
Pai	ent/Guardian Name & Contact Inform	nation (Nombre & Información del contac	cto)
	Name (Nombre)	8) Phone Number (Telé	
		() -	
0)	Emergency Contact (Contacto de emerg	gencia y Teléfono)	
		· , ,	() -
	Materia and the selfer O'ce's district		
•	form shall not relieve the liability of the s	school or its employees for their own neglige	d of Education and its employees from liability of any nature that might result from this plan of action. This ence. Also, I hereby give permission for the healthcare provider completing and signing this form to
	exchange information with JCPS staff re nealth services may also be provided by	egarding this health condition. I acknowledg	ge and agree when I authorize my child to attend a school sponsored field trip these medications and/or
			e at school for medications to be given at school
	PARENT/GUARDIAN Signature	TELEPHONE	-
	X	()	-
		HE HEALTHCARE PROVIDER ON	II V: Complete Items 12 17
Γ,-		ción para ser completada por el mé	·
2)	Student Diagnosis:		
	ADHD ICD 10 code:	Headaches	ICD 10 code: Urinary System Abnormalities ICD 10 code:
	Autism ICD 10 code:	Heart Condition	ion ICD 10 code: Other
	Bleeding/Clotting Disorder ICD 10 c	code: Psychiatric Co	Condition ICD 10 code: ICD 10 code:
	CP ICD 10 code:	_ Neurological	Disorder ICD 10 code:
3)	Precautions/Restrictions at school:		
4)	s suctioning needed at school?	ES, please complete below No	
	Туре		Instructions:
	Frequency?		
5)	s catheterization needed at school?	YES, please complete below No)
	Type		
	Frequency?		_
6)	Additional Health Care Provider's Comm	ments:	
71	Healthcare Provider Information Fo	orm must be signed by a Healthcare Provice	der and parent/quardian
1)	Healthcare Provider Signature	Date	Medical Office Stamp (required for processing)
	X		
	Healthcare Provider Printed Name	J L	