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
SCHOOL HEALTH PLAN
RESPIRATORY

School Year:

DO NOT WRITE IN THIS AREA
5367315987

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)*

5) School *(Escuela)* | **6) Grade** *(Grado)*

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

7) Name *(Nombre)* | **8)** Phone Number *(Teléfono)* ( ) - | **9)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

10) Emergency Contact (Contacto de emergencia y Teléfono) ( ) -

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: A prescription authorization form must be on file at school for medications to be given at school

PARENT/GUARDIAN Signature X | **TELEPHONE NUMBER** ( ) - | **DATE**

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) DIAGNOSIS: _____ ***LATEX ALLERGY/SENSITIVITY: ☐ YES ☐ NO**

13) TRACHEOSTOMY SUCTIONING/REPLACEMENT

Type and size of tracheostomy tube: _____

Suctioning Frequency (Check one and fill in):
- ☐ Every _____ hours
- ☐ As needed based upon signs and symptoms as follows
  - ☐ Choking ☐ Continuous coughing ☐ Gurgling ☐ Upon student's request
  - ☐ Other(specify):_____

Suctioning Instructions: (Parent/Guardian to supply saline and catheters)
- ☐ Depth to insert catheter:
- ☐ As needed based upon signs and symptoms as follows
- ☐ Other(specify):_____

In the event the tracheostomy tube becomes dislodged during the school day, may trained school personnel replace it? ☐ YES ☐ NO

14) VENTILATOR

Equipment Company/Phone Number: _____
Type of Ventilator: _____
Ventilator Settings: _____

Does student need ventilator at school? ☐ YES ☐ NO

Student needs ventilator: ☐ Continuously ☐ During Nap/Sleep Only ☐ Other:_____

Specific instructions for Ventilator (i.e. signs & symptoms to look for when taking naps/sleeping, etc.): _____

Additional Healthcare Provider's Comments: _____

15) OXYGEN SUPPLEMENTATION

Oxygen Vendor/Phone Number: _____

Liters per Minute: _____

☐ Nasal Cannula ☐ Mask ☐ Tracheostomy Collar

Times for Use:
☐ Continuous ☐ While Sleeping/Naps ☐ Respiratory Distress
☐ Other(specify):_____

16) PULSE OXIMETER

Use of pulse oximeter is only encouraged if the child routinely receives oxygen saturation monitoring at home. **(Parent/guardian to provide equipment needed for use at school.)**

Student's **NORMAL BASELINE** oxygen saturation is _____%

Please indicate when student should have oxygen saturation checked with a Pulse oximeter. (Check all that apply. If PRN provide SPECIFIC guidelines.):
- ☐ Before/after breathing treatments
- ☐ Signs of respiratory distress
- ☐ Other(specify):_____

- ☐ If sats. are below _____% Initiate Oxygen at _____ Liters/Min
- ☐ If sats. are between _____% & _____% call parent.
- ☐ If sats. are below _____% CALL EMS (911)

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

Healthcare Provider Signature X | Date

Healthcare Provider Printed Name

Medical Office Stamp (required for processing)

This institution is an equal opportunity provider and employer.