Jefferson County Public Schools Health Services
PCP Form/School Health Plan: Asthma/Allergy (Side One)
School Year:_____

JCPS Student ID# _____

Student Name: _____ **Date of Birth:** _____ **School:** _____

Does this child have ASTHMA? ☐ YES ☐ NO
Other Diagnosis: _____

What things may bring on this child's asthma?

☐ Pollens ☐ Dust ☐ Animals ☐ Exercise ☐ Foods ☐ Illness

☐ Other_____

Asthma SYMPTOMS may include:
Coughing · Shortness of Breath · Wheezing
Please list any other symptoms specific for this child:
Chest tightness

Asthma Medications AT SCHOOL:
Albuterol (Ventolin, Proventil, ProAir), Xopenex, Maxair (Circle)

■ 2 puffs every 4-6 hours as needed

☐ _____ puffs every _____ hours as needed

■ 2 puffs 15 minutes prior to exercise

☐ Nebulizer every 4-6 hours as needed_____

Other medications: _____
Instructions: Use with spacer

Is this student trained and capable of carrying their own inhaler and using it on their own? ☐ YES ☐ NO

EMERGENCY PLAN OF ACTION

1. Follow orders on page 1 & 2 for Allergy and/or Asthma treatments and medications.
2. If student is hunched over and/or having difficulty breathing, walking or talking, blue fingernails or lips, peak flow meter reading in red zone and/or medications not helping, call EMS 911.
3. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
4. Notify parent/guardian.
5. If EMS is called, the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
6. If student requires medical treatment while on the bus, the bus driver will contact EMS.
7. Other:_____
   _____

Does this child have NON-FOOD RELATED ANAPHYLACTIC ALLERGIC REACTIONS? ☐ YES ☐ NO

*****FOR FOOD RELATED ALLERGIES, COMPLETE SIDE TWO*****

Please list allergies.

☐ Medications: _____

☐ Stinging Insects: _____

☐ Other: _____

Allergic Reaction SYMPTOMS may include:
Itching/Swelling of Lips, Mouth, Tongue or Throat · Hives/Rash · Nausea/Vomiting/Stomach Cramps · Shortness of Breath · Wheezing · Coughing · Dizziness · Unconsciousness
Please list any other symptoms specific for this child:

_____

Medications AT SCHOOL:

☐ EpiPen Jr. ☐ EpiPen ☐ Twinject ☐ Auvi-Q
*EpiPen/Twinject/Auvi-Q to be given at onset of allergic reaction and/or exposure to allergy trigger.

***IF 2nd DOSE OF Twinject OR 2nd EpiPen/Auvi-Q NEEDED give:

_____Minutes after 1st Dose

May student carry own EpiPen/Twinject/Auvi-Q and use on their own?

☐ **YES** ☐ **NO**

☐ **Other medications:**_____

THIS 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	_____

Jefferson County Public Schools Health Services *JCPS Student ID#* _____

PCP Form/School Health Plan: Allergy/Asthma (Side Two)

School Year: _____

Student Name: _____ **Date of Birth:** _____ **School:** _____

Does this child have a FOOD RELATED ANAPHYLACTIC FOOD ALLERGY?

☐YES ☐NO

Please list: _____

Foods to OMIT: _____

Foods to Substitute: _____

Allergic Reaction SYMPTOMS may include:

Itching/Swelling of Lips, Mouth, Tongue or Throat · Hives/Rash · Nausea/Vomiting/Stomach Cramps · Shortness of Breath · Wheezing · Coughing · Dizziness · Unconsciousness

Please list any other symptoms specific for this child:

_____

Medications AT SCHOOL:

☐EpiPen Jr. ☐EpiPen ☐Twinject ☐Auvi-Q

*EpiPen/Twinject/Auvi-Q to be given at onset of allergic reaction and/or exposure to allergy trigger.

***IF 2nd DOSE OF Twinject OR 2nd EpiPen/Auvi-Q NEEDED give:

_____Minutes after 1st Dose

May student carry own EpiPen/Twinject/Auvi-Q and use on their own?

☐YES ☐NO

Other medications: _____

Nutritional information available at
www.jefferson.ky12.ky.us/Departments/NutritionServices

Does this child have a non-life threatening FOOD ALLERGY?

☐YES ☐NO

Please list: _____

Does this child have a FOOD/DAIRY INTOLERANCE? ☐ YES ☐ NO

Please list: _____

Food(s) to OMIT (Check all that apply):

DAIRY: ☐Fluid Milk ☐Cheese ☐Yogurt

☐Recipes with milk or milk products listed as an ingredient

EGG: ☐Whole Eggs (Scrambled Eggs)

☐Recipes with any egg listed as an ingredient

WHEAT: ☐Recipes with any wheat listed as an ingredient

FISH or SHELLFISH:

☐Specific fish or seafood type: _____

NUTS: ☐Peanuts ☐Tree Nuts

CORN: ☐Whole corn (Corn Kernel, Tortilla Chips, Corn Muffin)

☐ Recipes with corn listed as an ingredient (Corn Syrup, Corn Starch,etc)

OTHER: _____

Food(s) to substitute:

DAIRY: ☐Lactose Free ☐Soy Milk

OTHER: _____

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

Equal Opportunity/Affirmative Action Employer
Offering Equal Educational Opportunities

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

REV 4/2018