

Jefferson County Public Schools Health Services
Primary Care Provider (PCP) Authorization: Other Health Conditions (Side One)
2011-2012 School Year

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

DIAGNOSIS:

- | | |
|---|---|
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> ADHD/ADD |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Long QT Syndrome | <input type="checkbox"/> Ostomy Type: _____ |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> OTHER (SPECIFY): _____ | |

Latex Allergy Yes No

PRECAUTIONS AT SCHOOL: _____

RESTRICTIONS/EXCLUSIONS AT SCHOOL: _____

OTHER COMMENTS: _____

Nutritional information is available at
www.jefferson.k12.ky.us/Departments/NutritionServices
 or you may call 3186 for information.

Oral/Nasal Suctioning (circle one)

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

Suctioning Instructions:

- | | |
|---|---|
| <input type="checkbox"/> Oral Suctioning | <input type="checkbox"/> Nasal Suctioning |
| <input type="checkbox"/> Yanker/Soft tip catheter | <input type="checkbox"/> Saline Instillation needed |
| <input type="checkbox"/> 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:

<input type="checkbox"/> Clear	<input type="checkbox"/> Cloudy
<input type="checkbox"/> Odor	<input type="checkbox"/> Typically has blood in
<input type="checkbox"/> 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.**

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

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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 9-911.
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 emergency facility, or parent/guardian must sign release with EMS and parent/guardian then assumes responsibility for student. 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: _____

Form must be signed by health care provider and parent/guardian. If you have any questions please call (502) 485-3387 or Fax: (502) 485-3670.

Please return to:

Jefferson County Public Schools Health Services
Lam Building
4309 Bishop Lane
Louisville, KY 40218

 Printed Name MD, APRN or PA

 Address

 Telephone No./Fax No.

 Signature of MD, APRN, or PA

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 verify this information with JCPS and to consult with JCPS staff regarding this information. I also acknowledge that the emergency plan of action will most likely be administered by trained unlicensed JCPS personnel.

 Signature of Parent/Guardian

 Telephone No.

 Date

****Parent/Guardian signature required only for INITIAL 2011-2012 PCP form. Parent/Guardian signature not required for updated 2011-2012 PCP form.**

 Emergency Contact

 Telephone No.

 Relationship

FINAL April 4, 2011