

**Jefferson County Public Schools Health Services**  
*Primary Care Provider Authorization (PCP): Asthma/Allergy (Side One)*  
**2011-2012 School Year**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **School:** \_\_\_\_\_

**Does this child have ASTHMA?**     YES     NO

**What things may bring on this child's asthma?**

Pollens    Dust    Animals    Exercise    Foods  
 Illness    Other \_\_\_\_\_

**Asthma SYMPTOMS may include:** Coughing, Shortness of Breath, and Wheezing. Please list any other symptoms specific for this child:  
\_\_\_\_\_

\*Please refer to Emergency Plan of Action on Side Two for symptoms indicating an emergency asthma situation.

**Asthma Medications AT SCHOOL:**

Order will be for current 2011-2012 school year unless otherwise indicated.

Albuterol (Ventolin, Proventil, ProAir, etc)  
     2 puffs every 4-6 hours as needed  
     2 puffs \_\_\_\_\_ minutes prior to exercise  
     Other \_\_\_\_\_

Other medication \_\_\_\_\_  
    **Instructions** \_\_\_\_\_

\*If student needs inhaler more than twice a week, please notify parent.

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

**If student not carrying inhaler, it is to be kept:**

In front office or student classroom  
 Other \_\_\_\_\_

**Does this child have ALLERGIC REACTIONS?**     YES     NO

**What things cause this student's allergic reaction?**

Medications \_\_\_\_\_  
 Stinging Insects \_\_\_\_\_  
 Other \_\_\_\_\_

**FOOD ALLERGY?**     YES     NO

Please list any food allergies: \_\_\_\_\_

Any food not to be served to student: \_\_\_\_\_

Is student Lactose Intolerant?     YES     NO

Nutritional info available at [www.jefferson.kv12.kv.us/Departments/NutritionServices](http://www.jefferson.kv12.kv.us/Departments/NutritionServices) or you may call 485-3186 for more information.

**SYMPTOMS of the allergic reaction for this child:**

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

**Medications AT SCHOOL:**

Order will be for current 2011-2012 school year unless otherwise indicated.

EpiPen Jr.     EpiPen     Twinject  
 Give EpiPen/Twinject at onset of allergic reaction and/or exposure to allergy trigger.  
 Other instructions \_\_\_\_\_

\*\*\***IF 2<sup>nd</sup> DOSE OF TWINJECT OR 2<sup>nd</sup> EPIPEN NEEDED, give:**  
    \_\_\_\_\_ Minutes after 1<sup>st</sup> Dose

Other medications: \_\_\_\_\_

**May student carry own EpiPen/Twinject and use on their own?**

YES     NO

**If student not carrying EpiPen/Twinject, it is to be kept:**

In front office or student classroom     Other \_\_\_\_\_

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

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**2011-2012 School Year**

EMERGENCY PLAN OF ACTION

1. Follow orders on page 1 for Asthma and/or Allergy 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 9-911.
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: \_\_\_\_\_

**FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN**

\_\_\_\_\_  
Printed Name of MD, APRN, or PA      Address      Telephone No.

\_\_\_\_\_  
Signature of MD, APRN, or PA      Date      Fax Number

Parent/guardian hereby acknowledges that if this medication is not self-administered, it will most likely be administered by trained, unlicensed JCPS personnel. 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 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

**PLEASE RETURN THIS COMPLETED FORM TO:**

**Jefferson County Public Schools - Health Services Department**

**Lam Building, 4309 Bishop Lane, Louisville, KY 40218      Telephone No. (502) 485-3387      Fax: (502) 485-3670**

**FINAL April 4, 2011**