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) 485-3387

JEFFERSON COUNTY PUBLIC SCHOOLS
SCHOOL HEALTH PLAN
NON-FOOD ALLERGIES

School Year:

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: In order for medications to be administered, parent must complete an "Authorization for Medication" form for each medication needed at school.

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

PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 16
(12 al 16 - Esta sección para ser completada por el médico solamente.)

12) Please list allergies.

- ☐ Medications: _____
- ☐ Stinging Insects: _____
- ☐ Other: _____

13) Allergic reaction symptoms may include:
Itching/Swelling of Lips, Mouth, Tongue or Throat, Hives/Rash, Nausea/Vomiting/Stomach Cramps, Shortness of Air, Wheezing, Coughing, Dizziness, Unconsciousness

Please list any other symptoms specific for this child: _____

14) Device at School:

Name of Epinephrine device at school:_____ ☐ Epinephrine device not needed at school

* Epinephrine device to be given at onset of allergic reaction and/or exposure to allergy trigger.

15) May student carry own Epinephrine device and use on their own?

☐ Yes ☐ No

16) 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)