

Jefferson County Public Schools Health Services

Primary Care Provider Authorization: Food Allergies/Allergic Reactions/Anaphylaxis/EpiPen/Twinject (Side One)

2009-2010 School Year

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

ALLERGIC TO: Check appropriate box(es) and list specific allergies:

Foods _____ Medications _____

Insects _____ Other _____

Latex

Will the above allergen(s) produce an anaphylactic shock-like reaction?

Yes No

Does the child have an EpiPen or Twinject?

Yes No

If yes, then EPIPEN or TWINJECT SHOULD BE:

- kept with child
- kept in classroom with teacher
- kept in front office (or nurse's office if available)

Please mark symptoms that you know the child may exhibit:

- Mouth: Itching/swelling of lips/tongue/mouth
- Throat: Itching/sense of tightness in throat Hoarseness
- Skin: Hives Itchy rash Swelling of face/extremities
- Stomach: Nausea Abdominal cramps Vomiting
 Diarrhea
- Lungs: Shortness of breath Coughing Wheezing
- Heart: Weak pulse Loss of consciousness

The severity of symptoms can quickly change. All above symptoms can potentially progress to a life-threatening situation!

Does the child have asthma? Yes No **IF YES, PLEASE FILL OUT THE PRIMARY CARE AUTHORIZATION ASTHMA AUTHORIZATION FORM**

EMERGENCY PLAN OF ACTION

1. Administer emergency medication, if not applicable go to #2.

Medication: _____

Dose: _____

Route: _____

Second dose of Twinject or an additional EpiPen is needed:

\geq 5 minutes \geq 10 minutes Other: _____

2. 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.
6. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
7. If the student requires medical treatment while on the bus, the bus driver will contact EMS.
8. Other: _____

Please complete both sides of this form. Form must be signed by Health Care Provider and Parent/Guardian.

Jefferson County Public Schools Health Services

Primary Care Provider Authorization: Food Allergies/Allergic Reactions/Anaphylaxis/EpiPen/Twinject (Side Two) 2009-2010 School Year

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

PRIMARY CARE PROVIDER'S STATEMENT OF NUTRITIONAL AND DIETARY NEEDS

1. List all foods that should **NOT** be served to this student.

2. List any life threatening food-related allergies, which would/could produce an anaphylactic reaction upon exposure or ingestion.

3. List substitute foods for items in questions #1 and #2.

4. Does the student have special nutritional or feeding needs?

Yes No

If yes, detail specifics such as:

Textural Modifications Cut-up Ground finely

Chopped to bite size pieces Pureed

5. Indicate any other comments about the student's eating or feeding patterns/needs.

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

Printed Name of MD, ARNP, or PA

Address

Telephone No.

Signature of MD, ARNP, 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

Emergency Contact

Telephone No.

Relationship

Please return to: Jefferson County Public Schools Health Services, Lam Building, 4309 Bishop Lane, Louisville, KY 40218
Telephone No.: (502) 485-3387 Fax: (502) 485-3670

Final Revised March 31, 2009