

Jefferson County Public Schools Health Services

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

2008-2009 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

Please circle symptoms that you know child may exhibit:

Systems: _____ **Symptoms:** _____

Mouth	itching and swelling of the lips, tongue, or mouth
Throat	itching and/or a sense of tightness in the throat, hoarseness, hacking cough
Skin	hives, itchy rash, and/or swelling about the face or extremities
Stomach	nausea, abdominal cramps, vomiting, and/or diarrhea
Lungs	shortness of breath, repetitive coughing, and/or wheezing
Heart	“thread” pulse, “passing out”

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 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:

≥ 5 minutes ≥ 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. Other: _____
8. Other: _____

Jefferson County Public Schools Health Services

Primary Care Provider Authorization: Food Allergies/Allergic Reactions/Anaphylaxis/EpiPen/Twinject (Side Two)
2008-2009 School Year

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

PRIMARY CARE PROVIDER'S STATEMENT OF NUTRITIONAL AND DIETARY NEEDS

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

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

If yes, detail specifics such as:

- Textural Modifications
- Cut-up
- Chopped to bite size pieces
- Ground finely
- Pureed

2. List all foods that should not be served to this student.

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

4. List substitute foods for items in questions 2 and 3.

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

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

Printed Name of MD, ARNP, or PA

Address

Telephone No.

Signature of MD, ARNP, or PA

Date

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. Also, I hereby give permission for JCPS staff to verify this information regarding the above named child with the health care provider completing and signing this form.

Signature of Parent/Guardian

Telephone No.

Date

Emergency Contact

Telephone No.

Relationship

Please remember to complete both sides of this form.

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 May 6, 2008