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) 485-3670

JEFFERSON COUNTY PUBLIC SCHOOLS
SCHOOL HEALTH PLAN
Other Health Conditions

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 – 17
(12 al 17 - Esta sección para ser completada por el médico solamente.)

12) Student Diagnosis:

- ☐ ADHD ICD 10 code: _____
- ☐ Autism ICD 10 code: _____
- ☐ Bleeding/Clotting Disorder ICD 10 code: _____
- ☐ CP ICD 10 code: _____
- ☐ Headaches ICD 10 code: _____
- ☐ Heart Condition ICD 10 code: _____
- ☐ Psychiatric Condition ICD 10 code: _____
- ☐ Neurological Disorder ICD 10 code: _____
- ☐ Urinary System Abnormalities ICD 10 code: _____
- ☐ Other (1) DX:_____ Code: _____
  (2) DX:_____ Code: _____
  (3) DX:_____ Code: _____

13) Precautions/Restrictions at school:

14) Is suctioning needed at school? ☐ YES, please complete below ☐ No

Type _____ Instructions:_____

Frequency?_____

15) Is catheterization needed at school? ☐ YES, please complete below ☐ No

Type _____

Frequency?_____

16) Additional Health Care Provider's Comments:

17) **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)