School Year: _____

Lexington-Fayette County Health Department

School Health
650 Newtown Pike
Lexington, KY 40508-1197
(859) 288-2314
(859) 288-2313 Fax

PARENT PACKET - TRACH

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse at your school:

- **Student Health Information Sheet**
- **Physician Order for Tracheostomy Care & Parent/Guardian Statement**
- **Food Services Modification Form**

We are looking forward to a great year with your student!

Please call the School Health Services program at 288-2314 if you have any questions.

HEALTH INFORMATION SHEET

School Year: _____

Medical Condition: _____

(This form will be made available to teachers and appropriate school staff.)

Place Student's Picture Here

Student's Name: _____ **DOB:**____ **/** ____ **/** ____

Allergies: _____

School: _____ Teacher: _____ Grade: _____

Bus Rider: ☐ Yes ☐ No Bus #: AM _____ PM _____ Non-Transported ☐

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Alternate contact person in case of emergency:

Name: _____ Relationship: _____ Phone: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

HISTORY OF MEDICAL CONDITION - Include date of onset and most recent concerns: _____

_____

_____

* MEDICATIONS & TREATMENTS AT SCHOOL: _____

_____

_____

ADDITIONAL COMMENTS: _____

_____

_____

DATE COMPLETED: ____ / ____ / ____ COMPLETED BY: _____

* *Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

REVIEWED BY: _____***, RN*** ***DATE:*** _____ **/** _____ **/** _____

FOOD SERVICES MODIFICATION
EATING AND FEEDING EVALUATION

This form must be completed and signed by a Physician if your student requires a dietary restriction. (i.e. no peanut butter, no strawberries, etc.) OR a food substitute (i.e. allergic to cow's milk – substitute soy milk). This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.) This form is good for one school year and must be completed and signed by student's Physician to reverse a previous accommodation (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.)

PART A			
Name of Student:		**Date of Birth:** _____ / _____ / _____	
Allergies:			
Name of School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? If Yes, describe the major life activities affected.		☐ **Yes**	☐ **No**
Does student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed Physician.		☐ **Yes**	☐ **No**
IF STUDENT DOES NOT REQUIRE SPECIAL MEALS, PARENT/GUARDIAN CAN SIGN AT THE BOTTOM OF THIS FORM AND RETURN THE FORM TO THE SCHOOL'S FOOD SERVICE.			
PART B			
List any dietary restrictions or special diet:			
List any allergies or food intolerances to avoid:			
List foods to be substituted:			
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." **Cut up or chopped into bite-size pieces:** **Finely ground:** **Pureed:**			
List any special equipment or utensils that are needed:			
Indicate any other comments about student's eating or feeding patterns:			
Parent/Guardian's Signature: _____		**Date:** _____ / _____ / _____	
Physician's Signature: _____		**Date:** _____ / _____ / _____	

REVIEWED BY: _____ ***RN*** ***DATE:*** _____

School: _____ **School Year:** _____

PHYSICIAN'S ORDER FOR TRACHEOSTOMY CARE

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508

STUDENT'S NAME: _____ **Date of Birth:** ___ / ___ / ___

ALLERGIES: _____

DIAGNOSIS: _____

IS CHILD TRACH DEPENDENT? ☐ **Yes** ☐ **No**

TRACH TYPE: _____ **SIZE:** _____

TRACHEOSTOMY CARE DURING SCHOOL DAY: _____

Frequency of suctioning: _____

Care and cleaning of tube and stoma: _____

Other recommendations OR COMMENTS: _____

_____

PHYSICAL ACTIVITY RESTRICTIONS (PLEASE LIST): _____

_____

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

* ***PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication.***

PARENT/GUARDIAN STATEMENT

I, the undersigned Parent/Guardian of _____, hereby request the School Nurse or designee to administer the above procedure(s) according to the Physician's instructions. I will furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders.

PARENT/GUARDIAN SIGNATURE:_____ **DATE:** ____ / ____ / ____

Home Phone: _____ **Work:** _____ **Cell:** _____

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Reviewed by: _____ ***RN*** ***Date:*** _____