SCHOOL YEAR _____

Lexington-Fayette County Health Department

SCHOOL HEALTH DIVISION
650 Newtown Pike
Lexington, Kentucky 40508-1197
(859) 288-2314
(859) 288-2313 Fax

PARENT PACKET - CATHETERIZATION

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are the 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 & Parent/Guardian Authorization for Catheterization Procedure**

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.

STUDENT 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: _____

_____

_____

Parent/Guardian Signature: _____ Date: ____/_____/_____

* *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:*** _____/_____/ _____