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!

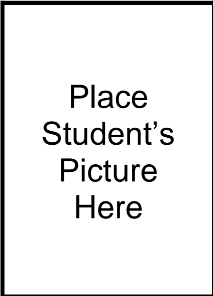
Please call the School Health Services program at 288-2314 if you have any questions.

HEALTH INFORMATION SHEET

School Year: _________

Medical Condition: ________________________________

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



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:* _____ / _____ / _____**

School: ____________________________________ School Year: _________

COPY TO: ☐ School Nurse
☐ Teacher
☐ Cafeteria Manager

Food Service Modification Form

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 must be completed and signed by the 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.) Once the form is on file, it will remain valid until a new form is presented.

PART A

Name of Student:		**Date of Birth:______/______/ ______**
Allergies:	**Is this Allergy Anaphylactic? YES NO**	
Current School:	**Grade:**	**Classroom:**
Does student have a Disability/Special Need? 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**

PART B

List any dietary restrictions/allergies or special diet: ________________________________

Food(s) to OMIT : ☐Fluid Milk ☐Cheese ☐Yogurt ☐Foods/recipes with milk or milk products as an ingredient

☐Whole eggs (scrambled, hard boiled) ☐Food/recipes with any egg listed as an ingredient ☐Wheat/Gluten

☐ Oats ☐Peanuts ☐Tree Nuts ☐Whole corn (corn kernel, tortilla chips, corn muffin, popcorn)

☐NO foods/recipes with corn listed as an ingredient (corn syrup, cornstarch, etc.) ☐ Shellfish ☐Fish

☐Other:________________________________ **For nutrition/ingredients for FCPS meals:** www.fayette.nutrislice.com

☐ List any foods to avoid for religious reason ** ☐ Pork ☐ Gelatin *****Religious reason does not require Physician Signature*

☐ Food Intolerance:________________________________ ☐ Avoid Red Dye ☐ Avoid Lactose

List foods to be substituted: ____

☐NO Substitutes required **Please Substitute with ☐ Lactose Free ☐ Soy Free ☐ Sun butter**

Texture Modification:	**Liquids:**	**Solids:**
	☐ Thin (Regular liquids)	**☐ Large foods cut into bite size**
	☐ Nectar Thick	**☐ Mechanical Soft (chopped)**
	☐ Honey Thick	**☐ Mechanical Soft (ground)**
	☐ Pudding Thick	**☐ Pureed (Applesauce texture)**

List any special equipment or utensils that are needed:

Indicate any other comments about student's eating or feeding patterns:

Which meals will your student eat from the Cafeteria? ☐Breakfast ☐Lunch ☐None (will bring from home)

Parent/Guardian's Signature: ______________________________	**Date:________/_______/ _______**
Physician's Signature: ______________________________	**Date:________/_______/ _______**

REVIEWED BY NURSING:______________________________***RN*** ***DATE:*** ____________________

Physician Order and Parent Authorization 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: ____

Student is Trach dependent? ☐ **Yes** ☐ **No** **HME to be use during school:** ☐ **Yes** ☐ **No**

Tracheostomy Type: __________________ **Size:** _______ **Depth to insert catheter:** _________

Passey Mulr/speaking valve: ☐ Yes ☐ No **Instructions:** _______________________________

Frequency of suctioning: __________________ **Saline Lavage:** ☐ **Yes** ☐ **No** ☐ **As Needed**

Student may provide self-care and suctioning: ☐ **Yes** ☐ **No**

In the event the tracheostomy tube becomes dislodged during the school day, trained personnel may replace it with a same size or smaller sized trach: ☐ **Yes** ☐ **No**

Care and cleaning of tube and stoma: ____

Other recommendations: ____

____

Physical Activity Restrictions (PLEASE LIST): ____

X ____ ____________________________
(Physician's Signature) Date

____ ____________________________
(Physician's Name - Printed) Telephone Number

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 give consent for **my student to self-administer** the above procedure, according to Physician's instructions. I agree to notify the school Nurse if monitoring is necessary. I agree to 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:** ____ / ____ / ____

PARENT/GUARDIAN NAME: ____________________ **Phone:** _______________ **Cell:** ___________________

****

Reviewed by: ___________________________________ ***RN*** ***Date:*** _______________________