Videographer/Photographer Approval (Athletics)

PRESS CREDENTIAL REQUIRED FOR VIDEOGRAPHY/PHOTOGRAPHY AT ATHLETIC EVENTS

A videographer/photographer wishing to record a District interscholastic athletic event shall contact the home school's athletic director prior to the day of the event to request approval. Submission of a request does not guarantee approval.

The home school athletic director shall approve a request for access to an event to a representative of a legitimate media outlet, including, but not limited to established newspapers, magazines, television stations, radio stations or networks, and recognized online news sources. Such approval shall be provided to a freelance or stringer videographer/photographer representing a specific legitimate media outlet. Approval is subject to availability of space and- shall be granted on a first-come, first-served basis.

The home school athletic director shall provide a press credential provided by the District Athletic Department for distribution to an approved videographer/photographer. The press credential must be worn visibly by the approved person at all times at the event.

A press credential is not transferable. Approval of a press credential may be rescinded by the home school's athletic director or school administrator at any time to maintain safety, eliminate disruptions or as a consequence of a violation of the general rules and professional etiquette provided below.

ELIGIBILITY FOR A PRESS CREDENTIAL

At any time, the District may request proof of a media outlet's legitimacy. To help the District protect access to its events, media members applying for credentials may be asked to provide samples of their work as well as information such as circulation numbers (newspapers/magazines), Nielsen Audio (formerly Arbitron) ratings numbers or similar information (broadcast), page views/hits (online entities).

Athletic recruiting promotion organizations or media outlets that can be construed as primarily recruiting publications will not be issued media credentials.

STUDENT VIDEOGRAPHERS/PHOTOGRAPHERS

A student videographer/photographer shall contact the home school's athletic director prior to the day of the event to request approval. Submission of a request does not guarantee approval. Upon approval, the student shall receive a credential to record the event.

GENERAL RULES AND PROFESSIONAL ETIQUETTE

A videographer/photographer shall conform to the following behavioral expectations at a District sponsored interscholastic athletic event. A videographer/videographer shall:

- Be courteous to other videographers/photographers, respecting the setups of others and avoiding blocking their shots;
- Not interfere with the action of the game or distract players, coaches, or referees.
- Stay within designated, roped-off areas.
- Respect emotional moments, including but not limited to, capturing reactions of athletes from a respectful distance at a game, respecting boundaries when a student is injured, allowing participants time and space before conducting an interview.

Videographer/Photographer Approval (Athletics)

- Know the sport and the venue, to assist in anticipating the action and avoid violating venue specific rules and requirements

Review/Revised:

Nurse Office Consent for Treatment/Emergency Information

Over the Counter Medications

The following are available to all students whose consent forms have been signed/returned:

Over the counter medications with medical provider or standing order only with parent/guardian consent.

Cross out any over the counter medications below you DO NOT want your child to receive.

Acetaminophen (Tylenol)
Ibuprofen (Motrin)
Midol (only for students age 12 and older)
Tums
Cough Drops/Throat Lozenges
Diphenhydramine (Benadryl) only for allergic reactions
Topical Antiseptic (Benzalkonium Chloride)
Hydrogen Peroxide
Lip Ointment (Chapstick/Carmex/Blistex/Vaseline, etc.)
Lotion
Hydrocortisone Cream 1%
Burn Cream
Sting Relief Swabs
Topical mouth/tooth pain relievers (Orajel/Anbesol)
Antibiotic Ointment (Neosporin/Bacitracin, etc.)
Eye Wash, Irrigating Solution

Reminders:

- The medications listed above will **only be given by licensed medical personnel** (Licensed Practical Nurse [LPN], Registered Nurse [RN], and/or Advanced Practice Registered Nurse [APRN]) when they are available in the building.
- Unlicensed school staff cannot give any of these medications, they may only be given by licensed medical staff.

Other Services Provided by School Nurses:

Health Assessments:

- Nursing assessment of health complaints, nursing management, and referral as needed.
- Hearing Screenings
- Dental Screenings
- Vision Screenings
- Immunization Outreach and Follow-Up
- Preventive Health Exam (APRN)

Health Education Services:

- Physical Health Conditions
- Physical and Dental Health Education
- Classroom Instruction per request as time allows
- School Health Plans:

Please Contact Your School Nurse If Needed

(Check if your child has any of the following):

☐ Asthma
☐ Dietary Needs (including food allergies)
☐ Allergy to something other than food
☐ Other Health Conditions (for other conditions not listed above)
☐ Diabetes
☐ G-Tube
☐ Seizure

School Nurses also provide care coordination by working with students, parents, and healthcare providers to manage chronic health needs.

Confidentiality:

All medical records are the property of District and protected under FERPA. No other agency will have access to these records without your written consent. We protect the privacy of your child's health information by:

- Limiting how we use and disclose health information.
- Providing physical safeguards (secure offices and storage facilities, electronic protections, and procedures.
- Training employees about privacy policies and procedures.

Nurse Office Consent for Treatment/Emergency Information

Consent for School Health Services **Please Return to School**
Jefferson County Public Schools
502-485-3387

Reviewed by: _____
Entered: ☐

CHILD/STUDENT INFORMATION

Grade _____ Team _____ Homeroom Teacher _____

Child's Last Name _____ First Name _____
(Please give child's complete legal name)

Child's Birth Date _____ ☐ Male ☐ Female

Street Address _____ City _____ Zip _____

Parent _____ Phone # 1 _____ Phone # 2 _____

Parent _____ Phone # 1 _____ Phone # 2 _____

Legal Guardian _____ Phone # 1 _____ Phone # 2 _____

Emergency Contact Person **OTHER** than parent or guardian _____

Emergency Contact Person Phone # 1 _____ Phone # 2 _____

Has your child EVER attended a Jefferson County Public School? ☐ Yes ☐ No
If YES, what School (s) did student attend in the past? _____

My child HAS the following **life threatening condition** that may need EMERGENCY TREATMENT or MEDICATION (Epi Pen, Glucagon, Emergency Seizure medications, Asthma Inhaler, etc.) at school:

☐ **Diabetes** ☐ **Asthma** ☐ Seizures ☐ **severe** allergies ☐ **Other:** _____

Is your child ALLERGIC to: (Check all that apply)

☐ **Medications:** Please LIST**:** _____
☐ **Peanuts:** EXPLAIN REACTION: _____
☐ **Tree Nuts:** EXPLAIN REACTION: _____
☐ **Bee/Wasp Sting:** EXPLAIN REACTION: _____
☐ **Other:** EXPLAIN REACTION: _____

CHILD'S Other Medical History (Heart Conditions, Cancer/Blood Disorders, Behavior Emotional, G-Tube, etc.):
Important medical history that staff should know about: _____
_____

Medications taken every day: _____
CHILD'S MEDICAL Insurance:
Does your child have a KY Medicaid Card? ☐ Yes ☐ No Medicaid Number: _____
Other Health Insurance? ☐ Yes ☐ No No Insurance? ☐ Yes ☐ No
Child's Health Care Provider: _____ Phone # _____
Child's Dentist: _____ Phone # _____

Nurse Office Consent for Treatment/Emergency Information

CONSENT FOR HEALTH SERVICES

- I consent to care for my child that may include screenings, exams, assessments, treatment, first aid, over-the-counter medications as listed on the Consent for Treatment form, and any other health services given to me/my child by staff/licensed volunteers of this School Health Office.
- I understand that I have the right to decline consent for health services relating to human sexuality, contraception, or family planning as indicated below. I understand that no guarantees are being made as to the effect of any exam or treatment on me/my child.
- I authorize the School Health Office to receive and release medical/dental/immunization/vision/hearing information about my child to their individual school, healthcare provider, immunization registry, or dental, vision, or hearing provider as needed or requested.

Signature: _____ Date: _____

OPT-OUT FOR HEALTH SERVICES RELATING TO HUMAN SEXUALITY, CONTRACEPTION, OR FAMILY PLANNING

I decline consent for health services specifically relating to human sexuality, contraception, or family planning.

Signature: _____ Date: _____

(Parent/Guardian) (Expires in one year)

A substantially equivalent electronic form may be used by the district in lieu of this paper form.

Review/Revised:7/29/2025

Nurse Office Consent for Treatment/Emergency Information

Jefferson County Public Schools

Please return to your child's school nurse

Student Information

Student Legal Name: _____

Date of Birth: _____ Grade: _____ School: _____

Home Address: _____

Parent/Guardian Name(s): _____

Phone #1 _____ Phone #2 _____

Emergency Contact (other than parent/guardian)

Name _____ Phone _____

Emergency and Medical Information

To help keep your child safe at school, please list any medical condition that may require care or emergency treatment during the school day (examples: asthma, diabetes, seizures, severe allergies, feeding-tube care, or heart conditions):

_____

_____

_____

Allergies (Check all that apply and describe reactions if known)

Medications ☐ Peanuts ☐ Tree nuts ☐ Milk / Dairy ☐ Eggs ☐ Shellfish ☐ Fish ☐
Wheat ☐ Soy ☐ Sesame ☐ Insect stings (bee/wasp) ☐ Latex ☐ Other ☐

Describe reaction:

_____

_____

_____

Nurse Office Consent for Treatment/Emergency Information

Daily Medications

List any medications your child takes regularly:

Medication _____ Dose/Frequency _____

Medication _____ Dose/Frequency _____

Health Care Information

Primary Healthcare Provider _____ Phone _____

Dentist _____ Phone _____

Health Insurance

Does your child have Medicaid ☐ Yes ☐ No If yes, please list their Medicaid number

_____

Other health insurance ☐ Yes ☐ No ☐ No insurance

Why School Health Services Are Provided

School nurses partner with families and schools to help students stay healthy, safe, and ready to learn. Some services are required by state law (such as documenting immunization compliance for school attendance). Other services ensure that health needs, including specialized medical care, do not interfere with a child's ability to attend school and fully participate in learning.

What Services the School May Provide

School health services may be provided in a school setting by licensed physicians, nurse practitioners, registered nurses, or licensed practical nurses, as allowed by Kentucky law. Health services may also be provided by trained school employees or health technicians who have been delegated responsibility by a physician or nurse and approved in writing to perform specific health services, in accordance with Kentucky law and district procedures.

Some services may be provided by trained school staff when permitted by law and appropriately supervised. **Unlicensed staff do not administer stock medications provided under standing orders or perform physical exams.**

If there are any services listed below that you **do not** want your child to receive, please cross out that service. Services may include:

- Nursing assessments and care management
- Vision, hearing, and dental screenings
- Preventive health examinations (physicals) provided by **nurse practitioners only**
- Health education (nurses only)
- Care coordination for ongoing or complex medical needs (nurses only)
- Assistance with medical equipment (such as feeding tubes) and other delegated tasks allowed by law
- Administration of medications as permitted by Kentucky law and district procedures

Nurse Office Consent for Treatment/Emergency Information

Important – This form **does not** provide consent for your child to receive any immunizations. Any immunizations offered at school require a separate, vaccine-specific consent form before they can be given.

Over-the-Counter Medications

The medications listed below may be available at your child's school. Per policy these medications may only be given by licensed nursing staff following standing medical orders. Please cross out any medications you do NOT want your child to be able to receive at school:

- Acetaminophen (Tylenol)
- Antibiotic ointment (Neosporin / Bacitracin, etc.)
- Burn gel or cream
- Calcium Carbonate (Tums)
- Cough drops or throat lozenges
- Diphenhydramine (Benadryl – mild allergic reactions only)
- Eye wash / irrigating solution
- Hydrocortisone 1% cream
- Hydrogen peroxide
- Ibuprofen (Motrin)
- Lip ointment
- Midol (ages 12+)
- Sting relief swabs
- Sunscreen
- Topical antiseptic (benzalkonium chloride)
- Topical mouth pain relievers

Health Information Release

I authorize the School Health Office to receive and share my child's medical, dental, immunization, vision, and hearing information only as needed to provide school health services, meet state school attendance requirements (including immunization mandates), and coordinate required screenings or follow-up care, including communication with: my child's healthcare provider(s), the Kentucky Immunization Registry (KYIR), school-based dental, vision, or hearing providers

This information will be used solely to support my child's health needs and ensure their ability to safely attend and fully participate in school.

Privacy Protection

All student health records are protected by the Family Educational Rights and Privacy Act (FERPA) and safeguarded through secure storage, limited authorized access, and staff privacy training.

Nurse Office Consent for Treatment/Emergency Information

Parent/Guardian Consent

I consent to the school health services described above, including only services that have not been crossed out, and understand that:

Services are provided by authorized school health personnel consistent with Kentucky law and nursing regulations

This consent does **not** authorize any immunizations

No guarantee is made regarding outcomes

This consent may be withdrawn or modified at any time

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Printed Name _____ **Phone** _____

Sexual Health Services – Optional Opt-Out

Please only sign this portion if you do NOT want these services for your child.

I understand that I may decline consent for school-based health services related to human sexuality, contraception, or family planning.

☐ I choose to opt out of these services.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____

An electronic version of this form may be used instead of this paper form.

Permission Form for Prescribed or Over-the-Counter Drugs

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____Date form received: _____

I/we acknowledge receipt of the Health Care Provider's Statement and Parent's Authorization.

Signature: _____

Student's Name: _____ Student's Age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PARENT/GUARDIAN

Name of medication: _____

Reason for medication: _____

ALLERGIES:_____

Any OTHER Condition(s) _____

Form of medication/treatment:

○ Tablet/capsule ○ Liquid ○ Inhaler ○ Injection ○ Nebulizer ○ Other _____

Instructions (Schedule and dose to be given at school): _____

Start: ○ Date form received ○ Other, as specified: _____

Stop: ○ End of school year ○ Other date/duration: _____

○ **For episodic/emergency events only**

Restrictions and/or important effects: ○ No restrictions

○ Yes. Please describe: _____

_____

Special storage requirements: ○ None ○ Refrigerate ○ Other_____

Health Care Provider Name _____

Address: _____ Phone: _____ FAX _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for _____ to receive the above medication at school according to
Student's Name

standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed. By completing this form, I give permission for JCPS staff to consult with the prescribing Health Care Provider or pharmacy regarding this information.

Date:_____ Signature: _____ Relationship: _____

Home phone:_____ Work phone: _____**Emergency phone: _____**

Permission Form for Prescribed or Over-the-Counter Drugs

PHYSICIAN OR AUTHORIZED HEALTHCARE PROVIDER ORDERS

For Self Administration of Medication

This student is capable, responsible, and has demonstrated self-administering the above medication

○ **Yes** - Unsupervised ○ **Yes** – Supervised ○ **No** This student should not self-carry medication

This student may self-carry this medication: ○ **Yes** ○ **No**

Note: the school nurse will also delegate and train unlicensed school personnel to give any emergency medication.

Signature: _____ Date _____

Physician or Authorized Provider: only valid for the current school year

For ALL Over-the-Counter Medications

ALL Over-the-Counter Medications can only be given with written orders from a healthcare provider

Signature: _____ Date _____

Physician or Authorized Provider: only valid for the current school year

A substantially equivalent electronic form may be used by the District in lieu of this paper form.

Review/Revised:8/11/2026

Notice to Individuals Regarding Title IX Sexual Harassment/Discrimination

This notice shall be provided to applicants for admission and employment, students, parents or legal guardians of students, employees, and all unions or professional organizations holding collective bargaining or professional agreements.

~~The District's Title IX Coordinator (TIXC) is~~

~~Dr. Georgia Hampton, Director of Compliance and Investigations~~

~~Jefferson County Public Schools~~

~~C.B. Young Service Center~~

~~3001 Crittenden Drive, Louisville, KY 40209~~

~~(502) 485-3341~~

~~georgia.hampton@jefferson.kyschools.us~~

Any person may report sex discrimination, including sexual harassment (whether or not the person reporting is the person alleged to be the victim of conduct that could constitute sex discrimination or sexual harassment), in person, by mail, by telephone, or by electronic mail, using the contact information listed for the Title IX Coordinator (TIXC), or by any other means that results in the TIXC receiving the person's verbal or written report. Such a report may be made at any time (including during non-business hours) by using the telephone number or electronic mail address, or by mail to the office address, listed for the TIXC.

District Title IX Coordinator

Office of Compliance and Investigations

Jefferson County Public Schools

C.B. Young Service Center

3001 Crittenden Drive, Louisville, KY 40209-1104

(502) 485-3341

The District must prominently display the contact information required to be listed for the TIXC and Policies 03.113, 03.212 Equal Employment Opportunity, 09.13 Equal Educational Opportunity, 03.1621, 03.2621, 09.428111 Title IX Sexual Harassment and 09.428111 AP.11 Title IX Grievance Procedures on its website, if any, and in each handbook or catalog that it makes available to persons entitled to a notification listed above.

The District must ensure that the TIXC(s), Investigators, Decision Makers, and any person who facilitates an informal resolution process, receive training on the regulatory definition of sexual harassment; the scope of the District's educational program or activities; how to conduct an investigation; the grievance process (including informal resolutions and appeals); and impartial service, conflict of interest, and bias standards.

The District must make these training materials publicly available on its website for inspection by members of the public.

REFERENCES:

Title IX of the Education Amendments of 1972 (20 USC § 1681, et seq.); 34 C.F.R. Part 106

Notice to Individuals Regarding Title IX Sexual Harassment/Discrimination

RELATED POLICIES:

03.113; 03.162; 03.1621; 03.212; 03.262; 03.2621; 09.313; 09.42811; 09.428111

RELATED PROCEDURES:

03.1621; 03.2621; (all procedures)
09.428111 (all procedures)

Review/Revised:9/1/2020

Telecommunication Devices

DEFINITION

As used in District policies and administrative procedures, "personal telecommunications device communications device" means an electronic device that is handheld or worn on the body having the ability to receive, record, and/or transmit voice, text, images, or data without a cable connection. A personal telecommunications device may include, but is not limited to, cellular telephones, smart phones, smart watches, smart glasses, tablets, radio-phones, walkie talkies,

~~Personal telecommunication device is defined in KRS 158.165 and includes, but is not limited to, cellular telephones, personal tablets, pagers, walkie-talkies, headphones, MP3 players, and video gaming systems.~~ The restrictions for student use of a cell phone in a school-based cell phone policy as required by this policy and related Administrative Procedure (09.4261 AP.2) shall apply to all student use of any personal telecommunications device.

SCHOOL-BASED CELL PHONE POLICIES

The School-Based Decision Making (SBDM) council or the Advisory Leadership Team in schools without an SBDM Council shall adopt a cell phone policy governing student use of personal telecommunications devices.

The cell phone policy shall be developed in accordance with the policy parameters and processes set forth in Administrative Procedure 09.4261 AP.2 School-Based Cell Phone Policies.

The policy:

1. Shall prohibit a student's use of a cell phone during the entirety of a school day, except during an emergency.
2. Shall provide for exceptions as set forth in Administrative Procedure 09.4261 AP.2.

CONSEQUENCES

When a student violates prohibitions of the school-based cell phone policy required under this policy and Administrative Procedure 09.4261 AP.2, the student shall be subject to interventions and consequences set forth in the Student Support and Behavior Intervention Handbook (SSBIH), including but not limited to losing the privilege of bringing the cell phone onto school property and being reported to the student's parent/guardian.

In the event of a violation, the principal or designated administrator may confiscate a student's cell phone and may make a report to the District Police Department as provided in the SSBIH and Administrative Procedure 09.461 AP.2.

NOTICE OF POLICY

Notice of interventions and consequences for violating the school-based cell phone policy shall be published annually in the SSBIH.

REFERENCES:

[1]KRS 158.165
KRS 525.080

RELATED POLICIES:

08.2323, 09.426, 09.436, 09.438

Telecommunication Devices

RELATED PROCEDURES

09.4261 AP.1; 09.4261 AP.2; 09.4261 AP.3

Adopted/Amended: 5/13/2025
Order #: 2025-084