

El Paso County School Health Services

Respiratory Specialized Healthcare Procedures Practitioner's Written Order

Student's Name: _____ DOB: _____
 School: _____ Year: 20 _____ - 20 _____

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the above school year or until there is a change or cancellation of the procedure(s).

Medical Diagnosis: _____
 Allergies: _____

Fill out the appropriate box and complete the related information

Oxygen Administration	
Brand/model: _____	Name of Durable Medical Equipment Company _____
☐ Compressed gas; tank size: _____	
☐ Liquid Oxygen	
Humidifier: ☐ No ☐ Yes-Amount of distilled water _____	
Nasal cannula; size: _____	
☐ Mask	
Tracheal device: _____	
Continuous Flow Rate _____ LPM _____	
PRN for the following symptoms or activities _____	Flow rate _____ LPM _____
Pulse Oximetry monitoring O2 Sat ranges _____	
Emergency if symptomatic or O2 Sat below _____	
Other: _____	

Oral/ Pharyngeal Suction	Nebulizer Treatment
Suction Device : _____	Give via : _____ Mask _____ Hand Held _____ Tracheal collar _____
Suctioning: q _____ hrs _____ prn	Medication: _____ Dosage _____ Time _____ Route _____
Other : _____	
_____	Administer TX for the following S&S : _____
_____	hrs/min x _____ times
_____	Give TX PRN for O2 Sats below : _____ q hrs/min x _____ times
	Other : _____

Tracheostomy
Tracheostomy Type: _____ Trach Cath : Size _____
Suction device: _____
Tracheal Suctioning: q _____ hrs or as needed Depth : _____ cm
Apply the following topical ointment _____ q _____ hrs or _____ PRN
Specific instructions for accidental dislodgment: _____

Ventilator	Chest Physiotherapy (CPT) Percussion and Postural Drainage
☐ Continuous	Area of Concentration : _____
☐ Other	Frequency : q _____ hrs/PRN
Emergency Instructions : _____	Other: _____
_____	_____
Other: _____	

Continuation on back

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Respiratory Specialized Healthcare Procedures Practitioner's Written Order**

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by licensed nurse/trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.

Practitioner's Name: _____

Practitioner's Signature

Office Phone Number

Date

To be completed by Parent/Guardian/Debe ser completado por Padre/Tutor

Authorization and Consent for Services

I request and authorize the school nurse and trained school personnel to perform or monitor the above ordered procedure as prescribed by my child's physician. I will provide the school with the necessary supplies/equipment to perform this service for my child. I will also provide written notification from the physician if the treatment changes or is discontinued. This authorization will be in effect for the above stated school year.

Autorización y Consentimiento Para Servicios

Solicito y autorizo a la enfermera y al personal escolar capacitado a realizar o supervisar el procedimiento prescrito por el médico de mi hijo/a, mencionado anteriormente. Proporcionare a la escuela con los suministros/equipos necesarias para llevar a cabo este servicio para mi hijo. También proporcionaré la notificación por escrito del médico si el tratamiento cambia o se discontinúa. Esta autorización estará en efecto para el susodicho año escolar indicado.

Parent/Guardian Signature

Date

Firma del Padre/Tutor

Fecha

Authorization to Release and Obtain Medical Information

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

Autorización Para obtener y Divulgar Información Médica

Autorizo la divulgación de información sobre los procedimientos y servicios especializados de salud relacionados con la condición de mi hijo entre el médico tratante de mi hijo/a, la enfermera de la escuela y personal de la escuela que necesita tener esta información para mantener la seguridad, la salud y el cuidado de mi hijo/a. Esta autorización estará en efecto para el susodicho año escolar indicado.

Parent/Guardian Signature

Date

Firma del Padre/Tutor

Fecha