



Carroll ISD Health Services
Parental Authorization for Respiratory Care Plan

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name: _____ D.O.B.: _____ Grade/Teacher: _____
 Parent/Guardian: _____ Phone: _____
 Parent/Guardian: _____ Phone: _____
 Transportation: Car rider Walker Drives self Rides bus # _____
 Before/After school activities: Athletics Band Club: _____ Tutoring Other _____

Background/History

Respiratory diagnosis: _____
Significant medical history: _____

What are the signs/symptoms of this respiratory condition? _____

Has student been hospitalized or treated in ER in the last 6 months for his/her respiratory condition? No Yes

List any medication taken at home on a regular basis: _____

List any emergency or "as needed" medication taken at home: _____

Respiratory Treatments/Procedures/Devices

Check all respiratory treatments, procedures, devices student uses at home and indicate whether they will be required at school:

At Home:	At School?
<input type="checkbox"/> Chest physiotherapy, type/schedule: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Ventilator, type/schedule: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Diaphragmatic pacer, type/schedule: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Tracheal suctioning, type/schedule: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Oxygen therapy, type/schedule: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Oxygen saturation measurement, type/schedule: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Peak flow monitoring, personal best number: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Other: _____	<input type="checkbox"/> No <input type="checkbox"/> Yes

Activity

Specify any activity restrictions, limitations, or modifications:

Physical Education: _____
 Outdoor recess: _____
 Athletics: _____
 Extra-curricular activities/events: _____
 Other: _____

Does student require any devices or equipment to assist with mobility? No Yes: _____

Nutrition

Check all that apply:

Regular diet
 Dietary restriction, specify: _____
 Dietary supplement, specify: _____
 Digestive enzymes (*medication order required*), specify: _____
 Tube feedings, specify: _____

Emergency Plan

Please describe below what constitutes an emergency or urgent situation for your child and the action to be taken.

If these signs or symptoms appear:	The action to take it this:

Medication at School

List any medication you would like student to receive on a regular or as needed basis while at school. Please complete a Medication Administration Request (MAR) form for each medication with specific instructions. Your student's physician must complete the MAR for each prescription medication.

Name of Medication	Dose/Route	Scheduled time or as needed	Reason for medication

Special Procedures/Treatments Needed at School

Name/Description of Treatment or Procedure	When is this to be performed?	Reason for Treatment/Procedure

I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.

Parent/guardian signature: _____ Date: _____