MECHANICAL VENTILATION ACTION PLAN

STUDENT____________________________________ D.O.B. __________________________

SCHOOL______________________________ TEACHER___________________ GRADE __________

PARENT/LEGAL GUARDIAN ____

PHONE: HOME___________________ WORK__________________ CELL __________________

Medical Diagnosis____

Reason for Ventilator ____

Ventilator Settings ____

Oxygen Source/Setting ____

Pulse Oximetry Order/Parameters____

Refer to Tracheostomy Action Plan for further information/orders.

Ventilator Company____

Phone______________________________________ Representative ____________________________

Alternate Phone ______________________________
(Parents will provide supplies/equipment.)

I, ____________________, authorize the physician's office to release confidential information about my child.

______________________________________ _________________________________
Parent/Legal Guardian's Signature Date

______________________________________ _________________________________
Physician's Signature Date

______________________________________ _________________________________
Physician's Printed Name Physician's Phone Number