Salem-Keizer School District 24J
Student Services
P.O. Box 12024
Salem, OR 97309-0024
(503) 399-3101

PROVIDER'S REPORT AND TREATMENT ORDERS
FOR RESPIRATORY CARE/AIRWAY MANAGEMENT AT SCHOOL
CONFIDENTIAL

PHYSICIAN'S AUTHORIZATION FOR ADMINISTRATION OF SPECIALIZED PHYSICAL HEALTH CARE SERVICES

PLEASE FAX TO STUDENT SERVICES AT (503) 316-3500

Student ID: _____ **Student Name:** _____ **DOB:** _____

School Name: _____ **Nurse:** _____ may be reached at (503) 399-3101

SUCTIONING

□ Nasal □ Oral □ Tracheal Frequency: _____

□ Straight suction catheter Size: _____ Length/Insertion Depth (cm): _____

□ Closed/In-line suction Size: _____ Length/Insertion Depth (cm/color): _____

TRACHEOSTOMY

Prescribed type/size: _____ □ Cuffed: air _____ ml □ Uncuffed

Emergency size: _____

Laryngotracheal separation □ Yes □ No

Inner cannula: Inserted at all times □ Yes □ No Frequency of change: _____

□ Tracheostomy change PRN occlusion/displacement

□ Saline drops PRN Number of drops: _____

VENTILATOR/OTHER RESPIRATORY PROCEDURES/OXYGEN/PULSE OXIMETRY

□ Ventilator: (attach order settings) □ Diaphragmatic pacer: (attach order settings)

□ Other respiratory procedure(s) at school: _____

□ Oxygen (O2) at school □ Continuous at _____ L/min

□ Start O2 at _____ L/min if SaO2 < _____%

□ Give _____ L/min to maintain SaO2 > _____%

□ Can titrate/discontinue O2 if SaO2 maintained at _____% for _____ min

□ Pulse oximetry □ Continuous □ Intermittent

Alarm settings: Low SaO2 _____% HR high _____/low _____

CALL 911 FOR ALL OR ONE OF THE FOLLOWING

1. SaO2 < _____% on room air or SaO2 < _____% on oxygen at _____L/min
2. Heart rate > _____bpm or < _____bpm
3. Respiratory rate > _____/min or < _____/min

PLEASE ATTACH ADDITIONAL ORDERS OR INFORMATION PERTINENT TO SCHOOL SETTING.

PHYSICIAN'S SIGNATURE INDICATES APPROVAL OF ABOVE ORDERS AS WRITTEN

Physician's Name (Print): _____ Signature: _____ Date: _____

Office phone number: _____ Office fax: _____