

SPECIAL EDUCATION DISTRICT OF LAKE COUNTY

18160 W Gages Lake Road, Gages Lake, Illinois 60030-1819

847-548-8470 Fax 847-548-8472 VP 224-207-8476

www.sedol.us



RESPIRATORY TREATMENT/PROCEDURE AUTHORIZATION FORM

Treatments cannot be administered at school without a doctor's written order and a written request from the parent or guardian.

School: _____

Student Name: _____ Birth Date: _____ Allergies: _____

Parent/Guardian Name: _____ Address : _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE PHYSICIAN:

Suctioning: Oral/Nasal (PRN), Tracheal (PRN)-depth _____ cm, Cath Size: _____

Oxygen: LPM via NC/mask/trach collar, continuous/PRN or at _____ for _____

Give PRN for oxygen saturations < _____% and continue checking pulse ox

Tracheostomy Tube: Reinsertion PRN, Size: _____, Step-Down Size: _____, Type: _____

Cuffed amount: _____,

Tracheostomy Care: _____

Ventilator:

PEEP: _____, FiO2: _____, Breath Rate (BR): _____, Tidal Volume (Vt): _____, Pressure Control (PC): _____,

Inspiratory Time (I-Time) _____, Pressure Support (PS): _____, Sensitivity: _____. Other: _____

Other Treatment/Procedure: _____

Frequency time while at school: _____ Duration: _____

Condition for which treatment is being given: _____ Special Considerations: _____

Must this treatment be administered during the school day in order to allow child to attend school or to address the child's medical condition? Yes: No:

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ **Office Phone:** _____ **FAX:** _____

PLEASE PRINT

TO THE PARENT/GUARDIAN:

All treatments to be administered at school must be supplied by the parent per SEDOL policy. This request terminates at the end of the physician's prescribed orders or the end of the current school year, whichever occurs first. SEDOL Nursing may consult with the prescribing physician regarding school medication and treatments.

By signing below, I agree that I am primarily responsible for administering treatments to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize SEDOL and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of SEDOL), lawfully prescribed medication/treatment in the manner described by the physician. I acknowledge that it may be necessary for the administration of treatment to my child to be performed by an individual other than a SEDOL nurse and specifically consent to such practices, and I agree to indemnify and hold harmless SEDOL and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of treatment.

I hereby request and grant permission for professional school personnel to administer the above prescribed treatment(s) to my child during the school day.

PARENT/GUARDIAN SIGNATURE

DATE

cc: SEDOL Nurse
Central File
Student ID#