ROCHESTER COMMUNITY SCHOOLS
PRIDE IN EXCELLENCE

School Year 2024-2025

ROCHESTER COMMUNITY SCHOOLS
RESPIRATORY Care

Child's picture
Face only

This form must be completed, signed, and ATTACHED to a Respiratory Medical Action Plan (MAP). Your child's health care provider will choose to either use their own MAP template, OR the Respiratory MAP template listed on the RCS website.

Student's Name: _____ School: _____
Date of birth: _____ Age: _____
Grade: _____ Teacher**:** _____

Transportation Office Use ONLY if needed
Bus # Driver: Route # Medical File

This MAP is validated with signatures and dates, by both the licensed health care provider (Doctor of Osteopathic Medicine, D.O., Medical Doctor, M.D., Nurse Practitioner, N.P., or Physician Assistant, P.A.), and a parent/legal guardian. Recommended orders for medical interventions within this treatment plan, will expire at the end of the 2024-2025 school year.

CONTACT INFORMATION

Call First:	Call Second:	Call Third:
Name:	Name:	Name:
Relationship:	Relationship:	Relationship:
Phone 1:	Phone 1:	Phone 1:
Phone 2:	Phone 2:	Phone 2:
Email:	Email:	Email:

PARENT/GUARDIAN CONSENT

I, (parent/guardian), _____, request that my child, _____, receive the attached medical management at school, according to standard school policy. I authorize consent to the ordering licensed health care provider staff and school to share information, as needed, to clarify orders and to assist with my child's health care needs. I agree to have the information, in this entire plan, shared with individuals that need to know. Also, I give permission to use my child's picture on this plan (if I did not supply a photo).

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

RESPIRATORY MEDICAL ACTION PLAN
Oxygen, Suctioning, Tracheostomy, and/or Ventilator Care

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

Tracheostomy Tube

Type / Brand: _____ Size: _____

☐ Cuffed ☐ Uncuffed ☐ Fenestrated ☐ Unfenestrated ☐ Other: _____

HEALTH CARE PROVIDER AUTHORIZATION
(Please use medication administration authorization form, as applicable)

☐ **Emergency kit / "Go-bag"** (It is the parent/guardian's responsibility to provide supplies and keep the kit updated.)
- ☐ Emergency kit available at school daily
- ☐ Other: _____

☐ **Utilize a humidification device.**
- Type: _____ Time(s) to be used: _____

☐ **Apply a speaking valve.** ***ONLY USE A SPEAKING VALVE WHEN A CUFF IS DEFLATED AND/OR FENESTRATED. SPEECH VALVES ONLY LET AIR IN, NOT OUT.**
- Type: _____ When to wear: _____

☐ **Perform oral, nasal or tracheostomy tube suctioning, to maintain patent airway.**
- Time(s) to perform suctioning: ☐ As needed ☐ Other: _____
- Suction machine setting: _____ mmHg Recommended suctioning depth: _____ mm
- Suction technique: ☐ Clean ☐ Sterile Catheter Size: _____
- Replace catheter: ☐ After each use ☐ At the end of the day

☐ **Provide tracheostomy tube site care.**
- Time(s) dressing should be changed: _____
- Dressing type: _____ Topical ointment application: _____
- Other: _____

☐ **Replace tracheostomy tube if it becomes dislodged or plugged with the type and size specified above or one size smaller.**

☐ **Monitor ventilator functioning using the following ventilator settings:**
- Mode: _____
- Inspiratory Time: _____ seconds
- Respiratory Rate: _____ breaths per minute
- Tidal Volume: _____ mL
- Pressure support (Above PEEP): _____ cmH2O
- PEEP: _____ cmH2O
- FIO2: ☐ 21% room air ☐ Other: _____
- High Alarm: _____ cmH2O
- Low Alarm: _____ cmH2O

☐ **Administer oxygen.**
- Keep SpO2 greater than: _____ %
- Administer oxygen: _____ liters per minute from portable oxygen tank kept at school
- Administer oxygen using: ☐ Nasal canula ☐ Simple face mask ☐ Partial rebreather mask ☐ Tracheostomy mask or direct connection ☐ Ventilator oxygen adapter and tubing

☐ **Other nursing orders**:

LICENSED HEALTH CARE PROVIDER (PRINTED)	TELEPHONE NUMBER
LICENSED HEALTH CARE PROVIDER SIGNATURE AND CREDENTIALS	DATE

Student Name:_____

Date: _____

EMERGENCY PREPAREDNESS IN THE EVENT OF

COMPLAINTS, OBSERVATION, ACCIDENTAL DECANNULATION, MUCUS PLUG, VENTILATOR INOPERATIVE

STUDENT COMPLAINTS/ OBSERVATIONS	STAFF ACTION	REGISTERED NURSE INTERVENTION
Unresponsive and not breathing	Notify nurse, if not already present, and follow directions as needed Maintain classroom and follow school protocols, activate critical incident team, call **911**, call parents AED on standby	Nurse will provide emergency care with ambu bag rescue breathing (1 breath every 2-3 seconds) If no resistance with bagging, attach bag to trach If resistance with bagging, plug trach (gauze or finger) and give breaths via face/mouth bagging Consider mucus plug, suction and may need replacement trach Monitor for cardiac arrest
Difficulty breathing, respiratory distress, change in color	Notify nurse, if not already present and follow directions, as needed Maintain classroom and follow school protocols, activate critical incident team, and call **911** and parents, as directed by nurse, or as needed	Consider mucus plug or other cause Reposition- stand or sit, student will not tolerate supine position (flat) Suction tracheostomy- if unable to pass catheter or no air movement is noted, replace trach Replace trach- if no improvement, plug trach and give breaths via face/mouth ambu bag If no improvement- c**all 911** and parents
Decannulation- Tracheostomy is accidentally removed	Notify nurse, if not already present and follow directions, as needed Maintain classroom and follow school protocols, activate critical incident team, and call **911** and parents as directed by nurse, or as needed	Replace trach using same size backup If unable to replace with same size, use downsize back up trach
Ventilator inoperative	Notify nurse, if not already present and follow directions, as needed Maintain classroom and follow school protocols, activate critical incident team, and call **911** and parents as directed by nurse, or as needed	Nurse will troubleshoot ventilator. Check battery indicator, extra battery in go bag Nurse will use ambu bag in the event of inoperative ventilator **Call 911** or parent for back-up ventilator, per nurse discretion

ROCHESTER COMMUNITY SCHOOLS
Authorization for Medication Administration
School Year: 2024-2025

Student name: _____ Date of birth: _____ Grade: _____

To be completed by the Physician or Authorized Prescriber: ONE MEDICATION PER FORM

(Michigan law and district policy require written authorization for a student to take any medication during the school day).

Name of medication: _____ Reason for medication: _____

Dose (***please do not give a range***): _____ ☐ MG ☐ MG/ML ☐ ML ☐ MCG ☐ UNITS ☐ OTHER: _____

_____

Route: ☐ Oral ☐ Injection ☐ Inhalation ☐ Intra-nasal ☐ Rectal ☐ Topical ☐ Transdermal (Patch) ☐ Other: _____

☐ Routine time(s) to be given: ☐ _____ AM ☐ _____ PM ☐ Other: _____

☐ Frequency: ☐ Daily ☐ Other (*please be specific*): _____

☐ As needed (PRN), (***absent clear and objective criteria, medication cannot be administered during the school day***):

_____

_____

Special instructions or side effects: _____

Student is both capable and responsible for self-administering this medication (***applicable ONLY to high school students***):
☐ No ☐ Yes- supervised ☐ Yes- unsupervised

Student may self-carry an inhaler (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable
Student may self-carry an Epi-Pen (***applicable to all students***). ☐ Yes ☐ No ☐ Not applicable

START: ☐ Date from received ☐ Other date/duration (please be specific): _____
STOP: ☐ End of school year ☐ Other date/duration (please be specific): _____

☐ For episodic/emergency events only

Prescriber Name: _____ Signature: _____ Date: _____

Clinic/Hospital Name: _____ Address: _____

Phone number: _____ Fax number: _____

To be completed by Parent/Legal Guardian

I understand and agree that all medication must be in the original container, clearly marked with the student's name, name of medication, and prescribed dosage. I acknowledge that I am required to immediately inform the District of any changes to the healthcare provider's administration instructions. Authorization also includes permission for school personnel and health care provider to contact each other, if needed. I request and authorize the following (***check appropriate direction below***):

☐ School personnel store and administer medication to the above-named student, as authorized by prescriber.
☐ School personnel store medication only. The above-named student shall be responsible for self-administering medication.

Printed Name: _____ Signature: _____ Date: _____

ROCHESTER COMMUNITY SCHOOLS

Medication Procedures

(as per standard school policy)

- Medication authorization is for the current school year only and will expire at the end of the school year.
- Only one medication per form. A separate form is required for each medication, each school year.
- Written authorization with medication order completed, signed by the student's authorized healthcare provider and a parent/guardian, is required before any medication can be given at school. Medications include prescription, and non-prescription over-the-counter, including but not limited to: homeopathic, herbal, vitamin, mineral preparation, topical creams or ointments, eye or ear drops, transdermal patches, nasal sprays or mists.
- Medication administration during school hours will be permitted only when failure to do so will jeopardize the health of a student, or the student would not be able to attend school if the medication or treatment were not available during school hours. Parents/legal guardians are urged to administer medication at home and on a schedule, other than school hours, if possible.
- Medication must be brought to school by the student's parent/legal guardian, unless the student has been authorized to self-carry the medication. The district reserves the right to determine that a student may not self-carry for any reason.
- Medication must be administered by an adult in the presence of a second adult, unless the medication is administered by a licensed registered professional nurse or there is an emergency that threatens the student's life or health.
- Parent/legal guardian will ensure that an adequate amount of medication is on hand at the school for the duration of the student's need to take medication, and responsible for checking the need for refills, including expired medications, and replenishing medication to the school in a timely manner.
- All medication must be in a container as prepared by a pharmacy, authorized healthcare provider, or pharmaceutical company, and clearly marked with the student's name, the name of the medication, the prescribed dose, time and frequency of medication administration and special instructions, if any.
- All controlled substance medication will be counted and recorded in the presence of the parent/legal guardian when brought to school.
- Changes in dosage, frequency, or time of administration cannot be made without written instruction from an authorized healthcare provider.
- Designated staff will be responsible for storage, administering medication and notifying parent/legal guardian, in the event that a student refuses medication.
- Medication left over at the end of the school year, or after a student has left the district shall be picked up by the parent/legal guardian. Any medication not retrieved by the parent/legal guardian will be properly disposed of within 7 days of the last student day of school and documented by the individual who is responsible for administering medication.