SPECIAL EDUCATION DISTRICT OF LAKE COUNTY
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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 saline 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#