OXYGEN ADMINISTRATION PERMISSION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

Student Name:_____ ID#:_____ Birthdate: _____

Grade/Teacher:_____

Address: _____
House Number / Street Apt # if necessary City ZIP

Both sections on this form need to be completed and are valid for current school year only, unless there is a change in the procedure or the procedure is discontinued.

☐ I give my permission for the above named student to be administered oxygen/compressed air at School.

☐ I give permission for the school nurse to communicate as warranted with the physician, hospital and/or respiratory therapist regarding my student's health concerns.

Printed Name: _____Home Phone: _____ Cell Phone: _____
Parent/Guardian printed name area code + number area code + number

Signature: _____ Date:_____
Signature of Parent/Guardian Month Day Year

PHYSICIAN INSTRUCTION:

☐ I request that the above named student be administered oxygen/compressed air at school.

Special Instructions:

Oxygen is to be administered via:

☐Nasal cannula ☐Facemask ☐Tracheostomy collar

Rate/dose of Oxygen: _____ Frequency: _____

Duration:_____ Oxygen Saturation Range_____

Other special instructions/information:

_____

_____

Physician's Printed Name: _____
Physician's printed name Medical Group/Clinic

Office Phone: _____ FAX NUMBER:_____
area code + number area code + number

Signature: _____ Date:_____
Signature of Physician Month Day Year

Please return completed form to School Health Office.