VENTILATOR DEPENDENT STUDENT INFORMATION FORM

HEALTH SERVICES

SCHOOL DISTRICT U-46

Please PRINT: School Year: _________

Student Name: ____
Last Name, First Name

Date of Birth ______________
Month Day Year

Parent/Guardian Name: ____

Home Phone: ( ) __________ Cell Phone ( ) __________ Work phone ( ) ________

Primary Physician Name: ________________ Office Phone: ( ) ____________

Specialty Physician Name: ________________ Office Phone: ( ) ____________

Private Duty Nurse: ____________________ Agency: ___________________

Office Phone: ( ) ______________________

Diagnoses (include all health concerns):

____

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____

Ventilator type: ___________

Settings: FIO_2 = ___________ Respiratory Rate = ___________

TV = ___________ PeakFlow= _______________

PEEP = ___________ Sigh = __________________

Physician's instructions (attach copy): ______________________________

Parent/Teacher/Student/Nurse Conference:

____
Time of Conference Date of Conference

Conference Participants: ________________ ________________

________________ ________________

________________ ________________

Transportation Conference:

____
Time of Conference Date of Conference