Clint ISD School Health Services
Respiratory Specialized Healthcare Procedures Practitioner's Written Order

Student's Name: _____ DOB: _____

School: _____ Year: 20 _____ - 20 _____

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the above school year or until there is a change or cancellation of the procedure(s).

Medical Diagnosis: _____

Allergies: _____

Fill out the appropriate box and complete the related information

Oxygen Administration

Brand/model: _____ Name of Durable Medical Equipment Company_____

_____ Compressed gas; tank size: _____

_____ Liquid Oxygen

_____ Humidifier: ☐No ☐Yes-Amount of distilled water _____

_____ Nasal cannula; size: _____

_____ Mask

_____ Tracheal device: _____

_____ Continuous Flow Rate _____ LPM _____

_____ PRN for the following symptoms or activities _____ Flow rate ___ LPM _____

_____ Pulse Oximetry monitoring 02 Sat ranges _____

_____ Emergency if symptomatic or 02 Sat below _____

_____ Other: _____

Oral/ Pharyngeal Suction	**Nebulizer Treatment**
Suction Device :_____	Give via : _____ Mask _____ Hand Held _____Tracheal collar
Suctioning: q _____ hrs _____ prn	Medication: Dosage Time Route
Other :	
_____	Administer TX for the following S&S : _____
_____	_____
_____	hrs/min x _____ times
	Give TX PRN for 02 Sats below : q hrs/min x times
	Other :

Tracheostomy

Tracheostomy Type: _____ Trach Cath : Size_____

Suction device:

Tracheal Suctioning: q _____ hrs or as needed Depth : _____ cm

Apply the following topical ointment_____q_____ hrs or_____ PRN

Specific instructions for accidental dislodgment:

_____

Ventilator	**Chest Physiotherapy (CPT) Percussion and Postural Drainage**
☐ Continuous ☐ Other Emergency Instructions : _____ _____ _____ Other: _____	Area of Concentration : _____ Frequency : q_____ hrs/PRN Other: _____ _____

Continuation on back

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I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by licensed nurse/trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.

Practitioner's Name: _____

_____	_____	_____
Practitioner's Signature	**Office Phone Number**	**Date**

To be completed by Parent/Guardian/Debe ser completado por Padre/Tutor

Authorization and Consent for Services

I request and authorize the school nurse and trained school personnel to perform or monitor the above ordered procedure as prescribed by my child's physician. I will provide the school with the necessary supplies/equipment to perform this service for my child. I will also provide written notification from the physician if the treatment changes or is discontinued. This authorization will be in effect for the above stated school year.

Autorización y Consentimiento Para Servicios

Solicito y autorizo a la enfermera y al personal escolar capacitado a realizar o supervisar el procedimiento prescrito por el médico de mi hijo/a, mencionado anteriormente. Proporcionare a la escuela con los suministros/equipos necesarias para llevar a cabo este servicio para mi hijo. También proporcionaré la notificación por escrito del médico si el tratamiento cambia o se discontinúa. Esta autorización estará en efecto para el susodicho año escolar indicado.

_____	_____	_____	_____
Parent/Guardian Signature	**Date**	**Firma del Padre/Tutor**	**Fecha**

Authorization to Release and Obtain Medical Information

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

Autorización Para obtener y Divulgar Información Médica

Autorizo la divulgación de información sobre los procedimientos y servicios especializados de salud relacionados con la condición de mi hijo entre el médico tratante de mi hijo/a, la enfermera de la escuela y personal de la escuela que necesita tener esta información para mantener la seguridad, la salud y el cuidado de mi hijo/a. Esta autorización estará en efecto para el susodicho año escolar indicado.

_____	_____	_____	_____
Parent/Guardian Signature	**Date**	**Firma del Padre/Tutor**	**Fecha**