

**Specialized Health Care Procedure:**

**Supplemental Oxygen Use via Nasal Cannula**

**Purpose:** Oxygen provides for body functions, relieves shortness of breath, and reduces the workload of the heart. Oxygen use is indicated for physical conditions in which a student is unable to get enough oxygen into the body or needs more oxygen.

**Requirements:** Parents/guardians are required to sign a written authorization for the use of oxygen. A written physician order must also be obtained. Parents/guardians are required to provide all necessary equipment/supplies.

**Personnel authorized to perform procedure:** Can be performed by an RN or LPN, or by any designated staff member trained by the nurse. Training will be reviewed on a yearly basis.

**Equipment required:** Oxygen gas tank with flowmeter; carrier; oxygen tubing; nasal cannula

**Special Considerations:** When in contact with a student using oxygen, the following warning is in effect:

- **There should be no smoking, open flame, or heat source close to the oxygen; these may increase the risk of fire.**
- **Equipment and oxygen supply must be checked at least daily, or more often, depending on the equipment.**
- **“Oxygen in use” signs must be posted when oxygen is in use.**

**Procedure:**

1. Wash hands.
2. Assemble equipment: oxygen source, cannula and tubing.
3. Explain procedure at the student’s level of understanding.
4. Attach cannula tubing to oxygen source securely.
5. Set liter flow on the flowmeter as prescribed by the physician. **Never change this setting without first contacting the physician.**
6. Check cannula prongs to make sure that oxygen is coming out.
7. Insert prongs into student’s nose. **Make sure both prongs are in the nostrils.**
8. Wash hands.
9. Document procedure and problems on student’s log sheet.

**Parent Authorization for Specialized Health Care Procedure**

I, the undersigned, who is the parent/guardian of \_\_\_\_\_ request that the following health care service:

**Supplemental Oxygen Use via Nasal Cannula**

be administered to my child. I understand that a trained designated staff member will be performing this procedure. It is my understanding that in performing this procedure, the designated person(s) will be using a standardized procedure which has been approved by our physician. I will notify the school immediately if the health status of our child changes, I change physicians, or there is a change or cancellation of the procedure.

**Signature of parent/guardian** \_\_\_\_\_

**Date** \_\_\_\_\_

**Physician’s Order for Specialized Health Care Procedure**

Student’s Name \_\_\_\_\_ DOB \_\_\_\_\_

**Procedure: Supplemental Oxygen Use via Nasal Cannula**

Check one:

- \_\_\_\_\_ I have reviewed the Health Care Procedure and approve of it as written.
- \_\_\_\_\_ I have reviewed the Health Care Procedure and approve of it with the attached amendments.
- \_\_\_\_\_ I do not approve of the Health Care Procedure. A substitute procedure is attached.

Duration of the procedure (not to exceed current school year): \_\_\_\_\_

**Physician’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_