Oxygen
Individualized Oxygen Action and Nursing Care Plan
for _______ School Year

This section to be completed by parent

Student’s Name_________________ DOB _______ Age_______
School ___________________ Grade______ HR Teacher__________

Significant Medical History: ____________________________________________
____________________________________________________________________
____________________________________________________________________

Allergies: __________________________________________________________________

Treating Physician_________________ Phone_________ Fax__________

This section to be completed by Physician

Current Medications: _____________________________________________________

____________________________________________________________________

Is Oxygen order: □ Continuous □ Intermittent
Method of administration: □ Mask □ Nasal Cannula □ Blow by □ Other _______________

Oxygen setting: ___________ FiO2/LPM

Is student on pulse oximeter: □ Yes □ No    Frequency: □ Spot checks every ________

□ Continuously (Alarms Limits: High_____
Low______)
□ With Sleep

Maintain O2 sats at > _____%

Emergency measures: Step1: If pO2 falls below___________ : increase oxygen rate to _______LPM

Step 2: If pO2 doesn’t increase or continues to decrease increase FiO2 up to _______ LPM

Step 3: Call 911.

SUPPLIES TO BE FURNISHED BY PARENT/GUARDIAN:

✓ Oxygen
✓ Nasal Cannula/Mask
✓ Pulse ox probes

Oxygen Tubing
Pulse oximeter

Physician’s Signature: ___________________________ Date: _________
Parent/Guardian Signature: ___________________________ Date: _________
Nurse’s Signature: ___________________________ Date: _________
LEON COUNTY SCHOOLS

AUTHORIZATION FOR MEDICATION OR TREATMENT

(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, ________________________________ (first/last name)/ ________________________________ (date of birth), to be given the medication or treatment listed below during the school day, including when she is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. Only FDA-approved prescribed and over-the-counter medicines will be accepted.

Name of medication: ____________________________________________________________

Reason for medication (diagnosis): ____________________________________________

Dosage to be given: ________________________________ Route (mouth, injection, etc.): ________________________________

Time(s) of administration: ____________________________________________________

Beginning date: ________________________________ Ending Date: ________________________________ Amount of liquid or count of pills: ________________________________

Emergency telephone numbers:

Parent/Guardian: ________________________________ H: ________________________________ C: ________________________________

Parent/Guardian: ________________________________ H: ________________________________ C: ________________________________

Doctor's Name: __________________________________________ Doctor's Phone Number: ________________________________

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall only be administered up to five calendar days without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy (see back of form).

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Date ________________________________ Parent/Guardian Signature ________________________________
**Leon County Schools**

**Authorization to Carry Medication(s) Permitted by Florida Statute 1002.20: Asthma Inhalers, Epinephrine Auto-Injectors, Diabetes Supplies or Pancreatic Enzymes**

Date: ____________________

Student Name: ____________________ DOB: ____________________

School: ____________________ Grade: ____________________

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It is medically necessary for this student to carry his/her medication and/or supplies while in school as permitted by Florida Statute 1002.20. This student is capable of self-management and administration of the following medication and/or supplies.

This authorization is valid for the current school year only (if for specific dates, please specify).

Medication and/or Supplies:

__________________________________________________

Dosage/Instructions:

__________________________________________________

Diagnosis:

__________________________________________________

<table>
<thead>
<tr>
<th>Physician Signature</th>
<th>Physician Name</th>
<th>Phone Number</th>
<th>Date</th>
</tr>
</thead>
</table>

I have read and understand the waiver of liability statements on the Authorization for Medication (Page 1) and feel that my child is capable of self-management and administration of the above medication/supplies.

<table>
<thead>
<tr>
<th>Parent Signature</th>
<th>Parent Name</th>
<th>Phone Number</th>
<th>Date</th>
</tr>
</thead>
</table>

***For staff use only***

The student has demonstrated that he/she is responsible in the use and storage of the above medication.

<table>
<thead>
<tr>
<th>FDOH RN Signature</th>
<th>FDOH RN Name</th>
<th>Phone Number</th>
<th>Date</th>
</tr>
</thead>
</table>
Florida Department of Health in Leon County
CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

School Year

Student’s Name: __________________________
DOB: __________________________
School: __________________________

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child’s medical condition with the following organizations:

(Please check and initial all that apply)

____ [X] Leon County School District
____ [ ] Tallahassee Memorial Hospital Diabetes Center
____ [ ] Children’s Medical Services
   (Name of case manager: __________________________)
____ [X] Florida Department of Health in Leon County (Health Department)
____ [ ] Tallahassee Pediatric Foundation

____ [ ] Primary Physician __________________________
   (Please fill in Physician name)
____ [ ] Specialist Physician __________________________
   (Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

________________________________________  __________________________
Signature                                          Date