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 s/he 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: _____ Allergies: _____

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 <u>within</u> 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: _____

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: _____

_____	_____	_____	_____
Physician Signature	**Physician Name**	**Phone Number**	**Date**

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.

_____	_____	_____	_____
Parent Signature	**Parent Name**	**Phone Number**	**Date**

For staff use only

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

_____	_____	_____	_____
FDOH RN Signature	**FDOH RN Name**	**Phone Number**	**Date**

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 inLeon 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