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	Oxygen Tubing
✓ Nasal Cannula/Mask	Pulse oximeter
✓ Pulse ox probes	

Physician's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Nurse's Signature: _____ 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 <u>all</u> 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