HEALTH SERVICES
Prosper Independent School District

Physician/Parent Authorization for Supplemental Oxygen

*This form to be renewed annually and as changes occur.

Student: _____ DOB: ____/____/____ Grade: _____ Date of Plan: ___/____/____

TO BE COMPLETED BY THE PHYSICIAN: Please complete this form based on your examination and knowledge of this student.

Diagnosis or description of condition that indicates use of supplemental oxygen:_____

_____

*Please attach a copy of any medical and developmental history that may be pertinent to the therapy program.

Type of Oxygen: ☐ High Pressure Gas Cylinder ☐ Liquid O2 ☐ Oxygen Concentrator

Oxygen is to be administered at _____L/min _____ concentration via: ☐ nasal cannula ☐ face mask ☐ trach

Does the oxygen need to be humidified? ☐ Yes ☐ No

Oxygen should be given: ☐ Continuously ☐ PRN for O2 sats ≤ _____% ☐ Other: _____

If Oxygen is to be administered PRN, how long should the oxygen be administered for and under what conditions should the student be returned to room air? _____

_____

Students requiring supplemental oxygen in the school setting will be assessed by an RN shortly after their arrival to the campus each day, and as needed. Is more frequent pulse oximetry monitoring required for this student? ☐ Yes ☐ No

If yes, how frequently? _____

When should the parent / 911 be notified?

☐ For O2 sats ≤ _____% that do not improve with prescribed supplemental oxygen after _____ minutes

☐ Other:_____

Precautions, possible untoward reactions, and interventions: _____

_____

Additional instructions regarding this procedure (Please attach facility protocol, if applicable) _____

_____

The procedure is to be continued as above until: _____

The parent is responsible to provide all equipment necessary for the supplemental oxygen at school. This includes the **portable oxygen tank and oxygen, spare oxygen tank (if needed), nasal cannula/face mask, and pulse oximeter**. Is there any additional equipment that the parent should provide in order to provide this care at school? _____

_____

Physician Name: _____ **Signature**: _____ Date:_____

Clinic/facility: _____ Phone: (_____)_____

TO BE COMPLETED BY THE PARENT/GUARDIAN ----------

I, the undersigned, the parent/guardian of _____ request that the above named specialized healthcare service to be administered to my child. I understand that it is my responsibility to provide the necessary equipment and supplies in order for the above healthcare service to be performed at school by district personnel. I understand that the school administration will appoint a qualified designated person to perform the above mentioned healthcare service. It is my understanding that in performance of the service, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I give my consent to release medical/health records and permission to appropriate school staff to contact the physician/health care provider for additional information if needed.

Parent's Signature: _____ Date: _____