PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of Oxygen in Educational Settings and Sponsored Events

School Year:

This authorization is valid for the current school year only

Student:	**DOB:**	**Date:**
District/Site:	**Teacher/Rm:**	**Grade:**

1. Oxygen Supply System:

☐ Compressed Gas: Tank Size _____

☐ Liquid Oxygen

☐ Oxygen Concentrator

Type: ☐ Portable ☐ Stationary

Brand Model: _____

2. Oxygen Delivery Device:

☐ Nasal cannula; Size _____

☐ Mask: _____

☐ Tracheal oxygen device

3. Humidifier Type

Amount of distilled water _____

Other directions: _____

4. Oxygen Administration Schedule

☐ Continuous

☐ Exercise/exertion

☐ Emergency

☐ When SaO_2 as measured by a pulse oximeter is less than _____

☐ As needed with the following symptoms:

- ☐ Increased breathing rate (tachypnea)
- ☐ Increased heart rate (tachycardia)
- ☐ Grunting
- ☐ Nose (nasal) flaring
- ☐ Sweating
- ☐ Changes in alertness, acting more tired and drowsy
- ☐ Morning and/or unexplained headaches
- ☐ Color changes (cyanosis, pale, or gray skin color)
- ☐ Wheezing
- ☐ Stridor
- ☐ Retractions or accessory muscle
- ☐ Shortness of breath (difficulty "catching" their breath or breathing hard)
- ☐ Other:

5. Pulse oximeter readings every (frequency) _____

6. Oxygen flow rate: ___Liters per minute

Change flow rate to: ___Liters per minute when: _____

Other flow rate parameters/instructions: _____

7. Medication Administration

☐ No

☐ Yes, Medication Form Attached

8. Notify health-care provider when: _____

9. Other pertinent information or recommendations:

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date**_____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

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for Management of Oxygen in Educational Settings and Sponsored Events

Student:	DOB:	Date:
District/Site:	Teacher/Rm:	Grade:

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the credentialed school nurse to communicate with the authorized health-care provider when necessary.

I (we) understand I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____