Physician Order for Administration of Oxygen

Name of Student:_____ Birth Date:_____

1. The above student is being treated for: (circle one)

   Asthma Apnea
   Cystic fibrosis Other:_____
   Seizures (specify)

2. Name of procedure: **Administration of Oxygen**
   The parent is required to provide the necessary supplies including O_2 source.

3. Procedure information:

   Full time_____ PRN_____

   Liter flow_____ Mask_____

   Canula_____

   Special instructions:_____

4. This procedure is not to be continued as above until:_____
   Date

All authorizations expire at the end of the current school year.

5. This procedure MUST be performed by licensed personnel **only**. Yes No
   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel. Please specify a person from your facility who can provide training for school personnel.

Name:_____ Phone:_____
Note: RN may need to contact physician in writing or by phone.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child.

_____ _____ _____
Signature of Parent/Guardian Phone Date