



Oxygen Administration Care Plan and Order for Prescribed Services

Student name: _____ DOB: _____

School: _____ Grade: _____ Date: _____

To Be Completed by A Healthcare Provider:

Students Medical Diagnosis: _____

Indications for oxygen administration: _____

Oxygen Administered by: Nasal Cannula Mask

Check Oxygen saturation as indicated: Yes No

When students oxygen saturation is: _____ Begin Oxygen administration at: _____

Can increase oxygen to: _____ until oxygen saturation is: _____

Target oxygen saturation is: _____

Notify parents if: _____

Call EMS if: _____

Other recommendations: _____

Date to be discontinued: _____

Licensed Health Care Provider Acknowledgement: I am aware that the parent/guardian in conjunction with the school/district licensed registered nurse will train the staff/unlicensed assistive personnel to perform this procedure while the student attends school. *Standards of care available upon request

Licensed Provider Name: _____ Phone No: _____

Licensed Healthcare Provider Signature: _____ Date: _____

Parent Acknowledgment: I agree with the above care plan and to provide necessary equipment/supplies properly labeled for use in school. I will work in conjunction with the school/district licensed registered nurse to train the staff/ unlicensed assistive personnel to administer the above procedure. If the procedure changes, written verification from your licensed health care provider is required. I grant permission for the registered nurse to communicate directly with the above-named provider, regarding any questions or concerns regarding this procedure or health related issues. I will notify the school of changes in procedure or provider.

Parent/Guardian Signature: _____ Phone No. _____ Date: _____