# Jefferson County Public Schools Health Services

*Primary Care Provider (PCP) Authorization: Respiratory Disorders (Side One)*

***2012-2013 School Year***

**Student Name: ________________________ Date of Birth: ___________ School: _____________________________**

*****DIAGNOSIS:_________________________________**

## TRACHEOSTOMY SUCTIONING/REPLACEMENT

**Type and size of trachea tube: ________________________**

**Suctioning Frequency (Check one and fill in):**

☐ Every _______ minutes ☐ Every _________hours

☐ As needed based upon signs and symptoms as follows:

- ☐ Choking ☐ Continuous coughing ☐ Gurgling
- ☐ Upon student's request ☐ Other (Specify): __________

**Suctioning Instructions: (Parents need to supply saline and catheters)**

☐ Saline installation needed ☐ Depth to insert catheter: _________

☐ Other (Explain): ________________________________

## VENTILATOR

**Equipment Company/Phone Number**: ____________________________

**Type of Ventilator:** ______________________________________

**Ventilator Settings:** ______________________________________

____________________________________________________

**Does student need ventilator at school?** ☐ **YES** ☐ **NO**

**Student Needs Ventilator:** ☐ Continuously ☐ During Nap/Sleep Only

☐ Other: ________________________________________

**Specific Instructions for Ventilator (i.e. signs & symptoms to look for when taking naps/sleeping , etc.):** ____________________________

____________________________________________________

**Additional Health Care Provider's Comments:** ______________

____________________________________________________

____________________________________________________

*****LATEX ALLERGY** ☐ **YES** ☐ **NO**

## OXYGEN SUPPLEMENTATION

**Oxygen Vendor/Phone Number:** ________________________

**Specific Instructions for use of Portable Oxygen:**

**Liters per minute: _______ via**:

☐ Nasal cannula ☐ Mask ☐ Tracheostomy collar

**Times for use:**

☐ Continuous ☐ While Sleeping/Naps ☐ Sats. ________________

☐ Respiratory Distress ☐Other___________________________

## PULSE OXIMETER

**Use of pulse oximeter is only encouraged if the child routinely receives oxygen saturation monitoring at home.**

Student's **NORMAL BASELINE** oxygen saturation is ______%

**Please indicate when student should have oxygen saturation checked with a pulse oximeter (Check all that apply. If PRN provide SPECIFIC guidelines):**

☐ Before every breathing treatment ☐ After every breathing treatment.

☐ When signs of respiratory distress (specify symptoms):_____________

____________________________________________________

☐Other (specify):__________________________________________

____________________________________________________

**Recommended Interventions (Check ALL that apply):**

☐ Encourage student to assume position of comfort

☐ Administer Nebulizer treatment/Inhaler (see Asthma PCP form)

☐ Encourage slow, deep, even breaths

☐ **If Sats are below _____% Initiate Oxygen at ________ Liters/Minute**

☐ **If Sats are between _____% & ______% call parent**

☐ **If Sats are below ______% CALL EMS (9-911)**

**Please complete both sides of this form. Form must be signed by Health Care Provider and Parent/Guardian**

| Initials/Date | |
|---|---|
| Reviewed by Health Services | ___________ |
| Entered by Health Services | ___________ |
| School received/sent to Health Services | ___________ |

# Jefferson County Public Schools Health Services

*Primary Care Provider (PCP) Authorization: Respiratory Disorders (Side Two)*

***2012-2013 School Year***

**Student Name:** ___________________________ **Date of Birth:** _________________**School:** _________________________________________

## EMERGENCY PLAN OF ACTION

1. Call EMS 9-911, if student's color becomes pale, cyanotic (bluish), or ashen OR student has other signs of respiratory distress (difficulty breathing, gasping, etc).
2. If tracheostomy tube becomes dislodged, trained personnel will replace and call EMS 9-911. If a nurse is present to evaluate and/or replace the tracheostomy tube, they will only call EMS as needed.
3. Notify school personnel trained in CPR/first aid to respond and initiate CPR if needed prior to EMS arrival.
4. Contact parent/guardian or emergency contact immediately.
5. If EMS is called the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day.
6. When student is transported via EMS a JCPS staff member must ride with student unless parent and/or emergency contact accompanies them.
7. **If student requires medical treatment while on the bus, the driver will contact EMS**
8. Other: ________________________________________________________________________________________________

**Form must be signed by health care provider and parent/guardian.**
**If you have any questions please call (502) 485-3387 or Fax: (502) 485-3670.**
**Please return to: Jefferson County Public Schools, Health Services, Lam Building, 4309 Bishop Lane, Louisville, KY 40218**

| ________________________ | ________________________ | ________________________ |
|---|---|---|
| Printed Name of MD, APRN, or PA | Address | Telephone No. |
| ________________________ | ________________________ | ________________________ |
| Signature of MD, APRN, or PA | Fax No. | Date |

Note to parent/guardian: Signing this form shall release the Jefferson County Board of Education and its employees from liability of any nature that might result from this plan of action. This form shall not relieve the liability of the school or its employees for their own negligence. Also, I hereby give permission for the health care provider completing and signing this form to verify this information with JCPS and to consult with JCPS staff regarding this information. I also acknowledge that the above procedures and emergency plan of action may be administered by trained unlicensed JCPS personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip these medications and/or health services may also be provided by a licensed volunteer.

| ________________________ | ________________________ | ________________________ |
|---|---|---|
| Signature of Parent/Guardian | Telephone No. | Date |

****Parent/Guardian signature required only for INITIAL 2012-2013 PCP form. Parent/Guardian signature not required for updated 2012-2013 PCP forms.**

| ________________________ | ________________________ | ________________________ |
|---|---|---|
| Emergency Contact | Telephone No. | Relationship |

3/14/2012