

Jefferson County Public Schools Health Services *JCPS Student ID#* _____
Primary Care Provider (PCP) Authorization: Respiratory Disorders (Side One)
2014-2015 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): _____

In the event the trach tube becomes dislodged during the school day, may trained school personnel replace it? YES NO

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: _____

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

*****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)

| |
|---|
| Initials/Date |
| Reviewed by Health Services _____ |
| Entered by Health Services _____ |
| School received/sent to Health Services & _____ |
| School Staff _____ |

Jefferson County Public Schools Health Services **JCPS Student ID#** _____
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2014-2015 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

EMERGENCY PLAN OF ACTION

1. Call EMS 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 may replace, if available, with extra tube (supplied by parent/guardian) and call EMS 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

Telephone No.

Signature of MD, APRN, or PA

Address

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 services may also be provided by a licensed volunteer.

Signature of Parent/Guardian

Telephone No.

Date

****Parent/Guardian signature required only for INITIAL 2014-2015 PCP form. Parent/Guardian signature not required for updated 2014-2015 PCP forms.**

Emergency Contact
Draft 4/2/14

Telephone No.

Relationship