Intermediate School District 917

Consent for Administration of Special Health Care Procedures: Respiratory Management
(Including suctioning, bronchial drainage, nebulization management)

Student _____ **Birth Date** _____**School Year** _____

Primary Dx_____ **ICD-10** _____

Dx_____ **ICD-10** _____ **Dx**_____ **ICD-10** _____

Parents/guardians requesting specialized procedures by school personnel . This procedure(s) will not necessarily be done by a school nurse. The procedure may be performed by school personnel trained and supervised by a Licensed School Nurse**.**

Parent/Guardian Release for Specialized Procedure(s)

Parent/Guardian Authorization

❑ I authorize the school nurse to contact the licensed provider as needed concerning this medication/s.

Provider/Clinic _____ Phone # _____ Fax # _____

- I understand that parent/guardian authorization is required for any prescription medication to be given at school. Prescription medications must have a physician or licensed provider authorization.
- I understand that I must provide all medication(s) and equipment for the procedure(s) below.
- I understand all medications must be provided with an accurately labeled prescription container. (Please ask your health provider for the medication to be divided into two containers-one for school, & one for home) Nonprescription medications must be in an original container with label and directions.
- I will notify the school immediately if my child's health status changes or there is a cancellation of the procedure(s).
- The medication may not necessarily be administered by a school nurse. The medications may be administered by school personnel trained and supervised by a licensed school nurse.
- I have read this *Parent/Guardian Authorization* section and agree to the instructions it provides.

Parent/Guardian Signature _____ **Date** _____

Physician's Orders

Type of oral secretion management:

❑ Oral pharyngeal suctioning w/ bulb syringe.

❑ Tracheal suctioning

❑ Positioning _____

❑ Other _____

❑ Precautions_____

Type of suction device/tip:

_____Soft catheter _____Yankeur _____Delee/bulb syringe Other _____

Respiratory management:

❑ Nebulization with _____ (medication/dose) every _____hours per:

_____Mask _____Blow by _____Trach dome _____Mouthpiece _____Other_____

Indications for Use _____

Precautions and/or adverse reactions _____

Bronchial drainage:

❑ Routinely at the following times _____

❑ As needed when:

_____Coughing/gagging _____Congestion or increased difficulty breathing

Other _____

Other instructions_____

Physician Signature _____ **Date** _____

For office use only:
LSN Signature _____ Date _____
Name of Staff Routing _____ Date _____
Please check off who was routed this form ___Student File __ IEP Manager ___ 917 LSN ___Building Nurse