JCPS Student ID#_____

Jefferson County Public Schools Health Services

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

2017-2018 School Year

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

DIAGNOSIS:_____

*****LATEX ALLERGY/SENSITIVITY: ☐ YES ☐ NO**

TRACHEOSTOMY SUCTIONING/REPLACEMENT

Type and size of tracheostomy tube: _____

Suctioning Frequency (Check one and fill in):

☐ 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 a Health Care Provider and parent/guardian.

OXYGEN SUPPLEMENTATION

Oxygen Vendor/Phone Number: _____

Specific Instructions for use of Portable Oxygen:

Liters per minute: _____

☐ Nasal cannula ☐ Mask ☐ Tracheostomy collar

Times for use:

☐ Continuous ☐ While Sleeping/Naps ☐ Respiratory Distress

☐Other_____

PULSE OXIMETER

Use of pulse oximeter is only encouraged if the child routinely receives oxygen saturation monitoring at home. Parent/guardian to provide equipment needed for use at school.

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/after breathing treatments

☐ Signs of respiratory distress

☐Other (specify):_____

_____

☐ **If Sats. are below _____% Initiate Oxygen at _____ Liters/Min.**

☐ **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	_____

JCPS Student ID#_____

Jefferson County Public Schools Health Services

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

2017-2018 School Year

Student Name: _____ Date of Birth: _____School: _____

EMERGENCY PLAN OF ACTION

1. Call EMS 911 for signs and symptoms of respiratory distress including: student becomes pale, cyanotic (bluish), or ashen in color, difficulty breathing, gasping, shortness of breath 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 an emergency facility, unless the parent/guardian signs a release with EMS. Parent/guardian then 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: _____

THIS FORM MUST BE SIGNED BY HEALTH CARE PROVIDER AND PARENT/GUARDIAN.

_____	_____	_____	_____	_____
Printed Name of MD, APRN, or PA	Signature of MD, APRN, or PA	Address	Telephone #/Fax #	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 #	Date

****Parent/Guardian signature required only for INITIAL(not updated) 2017-2018 PCP form.**

_____	_____	_____
Emergency Contact	Telephone #	Relationship

Please return to: Jefferson County Public Schools, Health Services Department, LAM Building
4309 Bishop Lane, Louisville, KY 40218
Telephone # (502) 485-3387 Fax # (502) 485-3670

Final 3/15/2017