Kauri Sue Hamilton School
Physician Order for Continuous Oxygen

To be completed by the students physician and parent and returned to Kauri Sue Hamilton School: Fax (801) 567-8522 or kshs.nurses-uc@jordandistrict.org

STUDENT'S NAME:_____ DOB: _____

DIAGNOSIS:_____

Indication: Student requires continuous supplemental oxygen at school in order to maintain oxygen saturations above 90%.

MD Order:

- ❏ Continuous oxygen at _____ L/min via Nasal Cannula _____ **OR** Face mask_____
- ❏ PRN oxygen at _____ L/min via Nasal Cannula _____ **OR** Face mask_____
  IF SpO2 is below < _____% on room air.
- ❏ Oxygen required on the bus: _____
- ❏ Oxygen may be removed for short periods of time for transfers and activity:_____
  If yes, for _____ minutes.
- ❏ Pulse oximeter monitoring: Continuous _____ PRN_____

Physician's Signature _____ Date:_____

Parent/Guardian Statement

- ❏ I, Parent/Guardian of _____, hereby request the School Nurse or trained staff member to administer the above procedure(s). I agree to furnish all equipment, tubing and other supplies necessary for the administration of the service/procedure listed above. **I agree to notify the School Nurse of any change made regarding the need for oxygen at school.**

  Parent/Guardian Signature: _____ Date: _____

  Phone: _____

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  Reviewed by: _____ RN Date: _____