

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) 587-8521



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: _____

Reviewed by: _____ RN Date: _____