St. Lucie PUBLIC SCHOOLS

SCHOOL BOARD OF ST LUCIE COUNTY
9461 Brandywine Lane, Port St. Lucie, FL 34986
772-429-4570

PHYSICIAN AUTHORIZATION AND TREATMENT FORM FOR OXYGEN ADMINISTRATION

STUDENT NAME: ________________________________ ICD-9: __________________
DATE __________________
DOB: __________________

PART 1: (Completed by Physician)

Administer _______________ Liters of Oxygen for O2 Sat below _____________%

Continue Oxygen for __________ minutes or until O2 Sat rises above __________%

Call 911 if O2 Sat remains below __________ % for __________ minutes.

Method of administration (please circle); mask --nasal cannula -- blow by--other

_________________________________ _____________________ _______________
Physicians Signature Printed Name Phone #

PART 11: (Completed by Parent)

I hereby request and give permission for my child to be given the above prescribed treatment/procedure while in school. I will notify the school immediately if the health status of my child changes, we change physicians, or if there is a change in treatment/procedure. I understand that if there is special equipment or supplies needed to perform this treatment/procedure, it will be maintained by me, delivered to the school in good working condition, and school personnel will assume no responsibility for the maintenance and/or delivery of special equipment/supplies.

_________________________________ _____________ __________________
Parent/Guardian Signature Date Phone #

PART 111: (For School Use)

School Nurse____ Date__________

Reviewed by ____ Date___________