



Physician Order for Administration of Oxygen

Name of Student: _____

Birth Date: _____

1. The above student is being treated for: (circle one)

Asthma

Apnea

Cystic fibrosis

Other: _____

Seizures

(specify)

2. Name of procedure: **Administration of Oxygen**

The parent is required to provide the necessary supplies including O₂ source.

3. Procedure information:

Full time _____

PRN _____

Liter flow _____

Mask _____

Canula _____

Special instructions: _____

4. This procedure is not to be continued as above until: _____

Date

All authorizations expire at the end of the current school year.

Name: _____

Phone: _____

Note: RN may need to contact physician in writing or by phone.

Physician's Signature: _____

Date: _____

Print Physician's Name: _____

Phone: _____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child.

Signature of Parent/Guardian

Phone

Date