Holly Area Schools

Respiratory Treatment Care Plan

This care plan is intended for nonasthmatic respiratory treatment. If student is an asthmatic please fill out the Asthma Care Plan

Student's Name: _____ School Year: _____

Date of Birth: _____ School/Program:_____

Age: _____ Grade: _____ Teacher: _____

First Contact	Second Contact
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone: _____	Phone: _____

I agree with this plan as written and for school staff to share this information with those that need to know. I agree for staff to contact the treating healthcare professional for clarification of this plan, if needed. This form is valid for one school calendar year and needs to be updated by a licensed medical provider if changes occur.

☐ YES ☐ NO I have read the attached information regarding section 504 eligibility

☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation

Parent/Guardian Name_____

Signature: _____ **Date:** _____

To be completed by the Physician:

☐ **Nebulizer Breathing Treatment:**

Medication: _____ Dose: _____

Frequency: _____ Indication: _____

May be repeated x _____ within _____ minutes, if needed.

☐ **Oxygen Therapy:**

☐ Nasal Cannula ☐ Face mask Liters of oxygen to be administered: _____

Oxygen saturation maintained above: _____ Liters

☐ Oral suctioning required Indication for suctioning: _____

Directions: _____

☐ **Other Respiratory Treatments or Directions:** _____

_____

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____