Holly Area Schools

Respiratory Treatment Care Plan

*This care plan is intended for **non asthmatic 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 certify that I have legal authority to consent to medical care/treatment for the student named above, including administration of medications at school. I agree with this plan as written and for school staff to share this information with those that need to know. I authorize HAS 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. I will not hold the HAS Board of Education, its personnel, or employees responsible for complications related to treatment/care provided pursuant to this plan.

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:** _____

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

5/2024 **Office Use:** Skyward Alert: ____ Email: ____ Date: _____ Initials: _____