Carroll ISD Health Services
Parental Authorization for Respiratory Care Plan 2020-2021

Parent please answer:	
Special Ed services?	yes / no
Active 504 plan?	yes / no
I would like 504 information	yes / no

Name:_____ D.O.B.:_____ Grade/Teacher:_____
Parent/Guardian: _____ Phone: _____
Parent/Guardian: _____ Phone: _____
Transportation: ☐ Car rider ☐ Walker ☐ Drives self ☐ Rides bus # _____
Before/After school activities: ☐ Athletics ☐ Band ☐ Club: _____ ☐ Tutoring ☐ Other_____

Background/History

Respiratory diagnosis: _____
Significant medical history: _____
_____
What are the signs/symptoms of this respiratory condition? _____
_____
Has student been hospitalized or treated in ER in the last 6 months for his/her respiratory condition? ☐ No ☐ Yes
List any medication taken at home on a regular basis: _____
_____
List any emergency or "as needed" medication taken at home: _____
_____

Respiratory Treatments/Procedures/Devices

Check all respiratory treatments, procedures, devices student uses at home and indicate whether they will be required at school:

At Home:	**At School?**
☐ **Chest physiotherapy, type/schedule**: _____	☐ No ☐ Yes
☐ **Ventilator, type/schedule**: _____	☐ No ☐ Yes
☐ **Diaphragmatic pacer, type/schedule**: _____	☐ No ☐ Yes
☐ **Tracheal suctioning, type/schedule:** _____	☐ No ☐ Yes
☐ **Oxygen therapy, type/schedule:** _____	☐ No ☐ Yes
☐ **Oxygen saturation measurement, type/schedule:** _____	☐ No ☐ Yes
☐ **Peak flow monitoring, personal best number**: _____	☐ No ☐ Yes
☐ **Other:** _____	☐ No ☐ Yes

Activity

Specify any activity restrictions, limitations, or modifications:

☐ **Physical Education:** _____
☐ **Outdoor recess:** _____
☐ **Athletics:** _____
☐ **Extra-curricular activities/events:** _____
☐ **Other:** _____

Does student require any devices or equipment to assist with mobility? ☐ No ☐ Yes: _____

Nutrition

Check all that apply:

☐ **Regular diet**
☐ **Dietary restriction, specify:** _____
☐ **Dietary supplement, specify:** _____
☐ **Digestive enzymes** ***(medication order required)*****, specify:** _____
☐ **Tube feedings, specify:** _____

Emergency Plan

Please describe below what constitutes an emergency or urgent situation for your child and the action to be taken.

If these signs or symptoms appear:	The action to take it this:

Medication at School

List any medication you would like student to receive on a regular or as needed basis while at school. Please complete a Medication Administration Request (MAR) form for each medication with specific instructions. Your student's physician must complete the MAR for each prescription medication.

Name of Medication	Dose/Route	Scheduled time or as needed	Reason for medication

Special Procedures/Treatments Needed at School

Name/Description of Treatment or Procedure	When is this to be performed?	Reason for Treatment/Procedure

I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.

Parent/guardian signature: _____ **Date:** _____