MECHANICAL VENTILATION ACTION PLAN

STUDENT____________________________________ D.O.B. ____________________________

SCHOOL_______________________________ TEACHER____________________ GRADE __________

PARENT/LEGAL GUARDIAN ____

PHONE: HOME____________________ WORK___________________ CELL ___________________

Medical Diagnosis____

Reason for Ventilator ____

Ventilator Settings ____

Oxygen Source/Setting ____

Pulse Oximetry Order/Parameters____

Refer to Tracheostomy Action Plan for further information/orders.

Ventilator Company____

Phone______________________________________ Representative ____________________________

Alternate Phone _______________________________
(Parents will provide supplies/equipment.)

I, ____________________, authorize the physician's office to release confidential information about my child.

______________________________	______________________________
Parent/Legal Guardian's Signature	Date
Physician's Signature	Date
Physician's Printed Name	Physician's Phone Number

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