LOS ANGELES UNIFIED SCHOOL DISTRICT
Office of the Chief Medical Director
District Nursing Services

MECHANICAL VENTILATION PRESCRIPTION

Student Name _____ Birth Date _____

Address _____
City Zip Code

School _____

Mode of Ventilation:

☐ Control ☐ SIMV ☐ Assist ☐ Pressure Limit

Degree of Dependency:

Sprints from Vent: ☐ Yes ☐ No

Frequency: _____ Hours

Normal Volume: _____

Rate: _____

Pressure Limit: _____

O_2 Flow Limit:

_____ LPM

_____ to _____ I:E Ratio (inspiration/expiration)

Sensitivity: _____

Sigh Volume: _____

Setting: ☐ On ☐ Off

High Pressure: _____

Low Pressure: _____

Other: _____

Physician's Name (print) _____

Physician's Signature _____ Date _____

Address _____
City Zip Code

Telephone (____)_____