



Home of the New Braunfels Unicorns!

NEW BRAUNFELS INDEPENDENT SCHOOL DISTRICT

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Physician and Parent Authorization for Tracheostomy Care

Name of Student: _____ Birthdate: _____ School Year: _____

To Be Completed by the Physician:

Physical Condition: _____

Tracheostomy Tube:

- Size _____
- Cuffed
- Uncuffed
- Use of heat and moisture exchanger, frequency of change _____
- Tube replacement if dislodged, tube size _____
- To be performed by: _____
- Precautions, possible reactions and interventions: _____

Suctioning:

- Oral - as needed
- Tracheal - as needed: depth _____ cm
Size of suction catheter _____
- Use of saline: amount _____ (gtts or cc)
- Clean cannula with: _____ (H₂O₂, alcohol, tap water, saline)
- To be performed by: _____
- Precautions, possible reactions and interventions: _____

Oxygen:

- Give _____ LPM via NC/mask/trach-collar
- Continuous or prn or at _____ for _____.
Time of day Condition
- To be performed by: _____
- Precautions, possible reactions and interventions: _____

Nebulizer Treatments: (See Asthma Action Plan for medication and dosage) Give via:

- Mask
- Hand held
- Trach collar
- Other: _____
- Give prn for oxygen saturations less than: _____
- To be performed by: _____

Passy Muir Valve:

- Frequency of use: _____
 - o _____ Minutes/Hours per day,
 - o _____ Times per week
 - o _____ Frequency for monitoring oxygen saturation
- Minimum oxygen saturation % at onset of use: _____
- Discontinue PMV should O2 sat % become less than _____
- Contraindicated for: _____
- To be performed by: _____
- Precautions, possible reactions and interventions: _____

Ventilator Care: _____

- To be performed by: _____

Physician/Health Care Provider's Name: _____ Phone: () _____

Physician/Health Care Provider's Signature: _____

To Be Completed By Parent or Guardian:

We will notify the school immediately if the health status of my child changes, we change physicians, or the procedure is changed or cancelled. We understand that, whenever possible, the specialized physical health care service should be provided before or after school hours.

I request these procedures be performed on my child according to the above instructions. I authorize the physician to release medical information regarding my child to school health or administrative personnel:

Parent or Guardian Signature Date

Address

Home Phone Work Phone Cell Phone

Please return to: _____
Nurse School Phone/fax