



TRACHEOSTOMY ACTION PLAN

STUDENT _____ D.O.B. _____

SCHOOL _____ TEACHER _____ GRADE _____

PARENT/LEGAL GUARDIAN _____

PHONE: HOME _____ MOBILE _____

Medical Diagnosis _____

Reason for Trach. _____

Nebulizer Order _____

Suction Orders _____

Lavage Orders _____

Pulse Oximetry Order/Parameters _____

ROUTINE TRACHEOSTOMY CARE WILL BE DONE AT HOME.

Go bag complete: _____ Yes (PARENT RESPONSIBILITY)

Supplies contained in Go bag:

Personnel who should be trained in emergency trach. care:

Car Rider _____ Bus Rider _____ Bus Number _____

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