DORCHESTER SCHOOL DISTRICT TWO
2023-2024 RESPIRATORY CARE REQUEST FORM

The following is to be completed by a physician/legal prescriber.

Name of Student: ____ DOB: ______ Grade/Section: ____________

Diagnosis: ____ ICD-10 Code: _________________________

Procedure(s) required while in the school setting (check and complete all sections that apply):

☐ **Tracheostomy Tube:** Trach Size: ___________ mm Trach Length: _________________
Trach Brand: ________________ ☐ cuffless ☐ cuffed with ___________ Secured with: ______________
If decannulation occurs, how long is this student stable until re-insertion can be completed? ___________________
If decannulation occurs, re-insert tracheostomy tube: ☐ yes ☐ no Emergency trach size: ___________ mm
☐ Passy-muir (speaking) valve used at school ☐ Cap trach while at school – frequency: ________________

☐ **Suctioning (check all that apply):** Suction Frequency: ___________ or ☐ PRN
☐ Tracheostomy ☐ Nasal Tracheal ☐ Suction Machine Recommended Depth: _______
Trach Suction Catheter type: ☐ Closed System ☐ Sterile Suction Catheter ☐ Clean Suction Catheter
Use: ☐ Trach Suction Catheter Size: _______ fr -or- ☐ Yankauer Replace: ☐ each use -or- ☐ end of day
☐Suction with Saline: PRN (thick secretions)
☐ Sterile Saline ☐Non Sterile Saline ☐Trach Toilettes ☐ Amount of saline to use:______ gtts or ml
☐ HME (Humidification Valve) Thermovent - Frequency: ____________________

☐ **Pulse Oxygen Monitoring:** ☐ Continuous ☐ Intermittent – note time(s): __________ ☐ PRN
Treatment parameters for decreased SpO2: ____
☐ **Oxygen Therapy:** ☐ At School ☐ On Bus ☐ PRN
☐ Oxygen Setting: __________________ Does student require Humidified Oxygen: ☐ Yes ☐ No
Oxygen route: ☐ Trach via mask ☐ Trach via T-valve ☐ Nasal cannula ☐ Face mask ☐ Vent
Administer O2 if SpO2 < ______% or the following signs are noted: ___________________________________

☐ **Special Instructions:** ____
____

______________________________ ______________________________ ______________
Signature of Physician/Legal Prescriber Phone Number Date

The following is to be completed by a parent/legal guardian:

I request the above procedure(s) to be administered to my child as ordered by the physician or legal prescriber and hereby release everyone participating in this request from any and all liability associated therewith or stemming therefrom. I authorize the school nurse to contact my child's provider for information concerning my child when necessary.

______________________________ ______________________________
Signature of Parent/Legal Guardian Date