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:____________________________
  - ______Minutes/Hours per day,
  - ______Times per week
  - ______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: ____

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- 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