

**SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR TRACHEOSTOMY CARE**

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____

Known drug allergies/reactions If drug allergies, list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ **STOP DATE:** _____

Tracheostomy Tube Info.

Brand: _____ * Size: _____ Length: _____

Check all that apply: Cuff Non-cuff Trach Tapes to hold in place

If yes, location of replacement tube: _____

Student will have Emergency Kit/"Go Bag" at school daily.

Humidifier Type:

Required care: _____

Tracheostomy Suctioning Orders:

Suction machine: Set to _____ mm Hg Will remain at school Will travel with student back & forth from school

Recommended depth for suctioning: _____ mm

Irrigate with normal saline prior to suctioning? No Yes PRN only Describe circumstance for prn saline w/suctioning: _____

Written instructions for cleaning machine are to be provided by parent and/or healthcare provider and are to be included in student's Individualized Healthcare Plan.

Suction Technique: Clean Sterile Catheter Size: _____ Replace catheter: Each time suctioned End of one day

***Is student authorized to complete self-suctioning care?** Yes No

If "yes", I hereby affirm that this student has been instructed in proper self-care for suctioning technique.

Unless student is authorized to perform self-care, all tracheostomy suctioning care will be provided by the licensed school nurse.

Tracheostomy Tube Replacement Order in Event of Accidental Decannulation:

I hereby authorize the Licensed School Nurse, who has received training and successfully completed a return skill demonstration, to replace this student's tracheostomy tube with * same size or one size smaller

Is student's breathing assisted via ventilator? Yes No

If "yes", please provide the following:

Ventilator Brand: _____

Ventilator Settings: _____

Printed Name of Licensed Healthcare Provider _____

Signature of Licensed Healthcare Provider _____ Date _____ Phone _____ Fax _____

PARENT AUTHORIZATION

I understand that additional parent/prescriber authorization forms will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedures. Procedure equipment and/or supplies must be registered with the licensed school nurse or his/her designee.

Signature of Parent _____ Date _____ Phone _____ Cell _____

PARENTAL SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the *above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

Signature of Parent _____ Date _____ Phone _____ Cell _____