



DORCHESTER SCHOOL DISTRICT TWO 2024-2025 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: _____ gtt/s 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 that the above respiratory procedure(s) 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 understand that I am responsible for providing all supplies and equipment necessary for carrying out these orders at school.
- I authorize the School Nurse to contact my child’s provider for information concerning my child when necessary.

 Signature of Parent/Legal Guardian Date