School Year: _____

CONSENT AND ORDER FOR SPECIALIZED SUCTION/OXYGEN/ TRACHEOSTOMY- HEALTH SERVICES

PARENT/GUARDIAN CONSENT FOR SPECIALIZED SUCTION/OXYGEN/ TRACHEOSTOMY

I give my permission for the school nurse or a staff member trained by the school nurse to perform the following specialized nursing intervention or treatment prescribed by_____ (Physician or Licensed Care Provider) and to contact the Physician regarding any treatment orders, the implementation of the orders, and the outcomes from these treatments. I request that the school continue the intervention or treatment for the duration of the school year or until notified by me or the Physician to change or discontinue. Notice of change must be received in writing. Orders must be renewed annually.

_____ _____

Parent/Guardian Signature Date

PHYSICIAN ORDER FOR SPECIALIZED SUCTION/OXYGEN/ TRACHEOSTOMY

Student Name_____**Allergies**_____**Date of Birth**_____

Condition/Diagnosis: _____

Specialized Intervention: ☐ **SUCTION** ☐ **OXYGEN** ☐ **TRACHEOSTOMY**

Suction:

Type of Suction: ☐ Oral ☐ Nasal ☐ Deep ☐ Tracheostomy

Method of Suction: ☐ Yankauer ☐ Catheter ☐ Inline Suction Catheter

Catheter: Size: _____ Depth: _____ Time(s)/Frequency: _____

Use of Normal Saline drops: ☐ NO ☐ YES If Yes: ☐ Nose ☐ Trach.

Oxygen:

02 Sat Monitoring: ☐ Continuous ☐ Spot Check

02 Sat Parameters: _____

Oxygen Parameters: This student can have up to _____ Liters of 02 via_____

Tracheostomy: Trach Type & Size: _____ ☐ Uncuffed ☐ Cuffed

If Cuffed Trach, Place: _____ML of: ☐ Sterile Water ☐ Air

PMV: ☐ YES ☐ NO

Any other Precautions, possible side effects, and recommended interventions: _____

_____

Physician name (please print) _____

Address_____ Phone_____ Fax #:_____

Physician Signature: _____**Date**: _____

*If completed by a nurse practitioner, please indicate the physician in collaborative practice.

Please return by mail or fax to the address or fax # below:

School Name: _____ School Address: _____

Phone: _____Fax: _____ Requesting Nurse: _____