



TRACHEOSTOMY ORDERS

Student Name: _____ Date of Birth: _____

Trach size: _____ Cuffed/Uncuffed

Trach care/Frequency: _____

Tracheal Suction frequency _____ Suction catheter size _____

Instill Saline Y/N If Yes: Amount _____

Oral Suction PRN Y/N

Scheduled O2 Saturation Check Y/N _____ Frequency _____

PRN O2 Saturation check _____

O2 via Tracheostomy Y/N O2 Saturation parameters _____ Rate _____

Additional Orders _____

Contact Parent for _____

Physician/Licensed Health Care Clinician Name (printed) _____

Phone (____) _____ Fax (____) _____

Address: _____

CLINICIAN SIGNATURE _____ Date: _____

PARENT/GUARDIAN PERMISSION:

I hereby give my permission for the school nurse, supplemental trained staff or trained school employee(s) to carry out the above orders for my child (named above) during school hours. These orders have been prescribed by a licensed physician or other health care clinician.

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

School Nurse Signature _____ Date: _____