

**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)

ALL ORDERS ARE GOOD FOR ONE CALENDAR YEAR

UNLESS OTHERWISE NOTED WITH "STOP DATE"

START 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.

STOP DATE:

**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 \_\_\_\_\_