



Request for Tracheostomy and/or Ventilator Care by School Personnel

- This form must be kept on file in the school clinic and incorporated into the student's Individualized Healthcare Plan (IHP) and Emergency Action Plan (EAP).
- The student must have an Emergency Kit ('Go Bag') available at school each day.
- If student authorized to utilize school transportation, the vehicle is expected to pull off the road for the administration of medical care

STUDENT INFORMATION

Student's name: _____ Date of Birth: _____ Weight: _____ lbs
School: _____ Grade: ____ Age: ____ Teacher: _____
Known drug allergies: _____
Reaction: _____

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Start date: _____ Stop date: _____

Transportation Authorization

Student is authorized to utilize school transportation Y N

Tracheostomy Tube Information

Student is trach dependent (no air exchange) Student is not trach dependent

- Tube type/brand: _____
- Size: _____ Length: _____
- Cuff: Yes No Method of Securement: Ties Tape Other: _____
- Inner cannula: Yes No Clean inner cannula: Yes No
If yes, with what? _____
- Replacement tube available at school: Yes No
- Humidifier type: _____ N/A

Speaking Valve

Yes - type: _____ No

Instructions: _____

Tracheostomy Suctioning Order (Open System Closed System)

- Suction technique: Clean Sterile
- Pressure: _____ mm Hg
- Depth: _____ mm
- Catheter size: _____
- Frequency: _____ Indication for: _____
- Limits: _____
(max # of passes, max duration per suction attempts)
- Replace catheter: Each time suctioned End of day

Tracheostomy Tube Replacement

Tube size: _____

Replace tube when: Tube becomes dislodged Unable to clear mucus

Do not replace tube, action to take: _____

Emergency action plan when reinsertion is unsuccessful: _____

Ventilator (if applicable)

- Is a ventilator required? Yes No PRN (parameters) _____
 - Brand/model: _____
 - Settings: _____

Other Pertinent Information or Recommendations

Authorized healthcare provider name (print)

Provider's complete address

Office telephone

Alternate emergency number

Provider's signature

Date

PARENT AUTHORIZATION

I hereby request and give my permission for school district personnel to perform any of the above identified procedures on my child in accordance with the specific written instructions of our medical provider. I do hereby release all school employees and the Board of Education from liability for damages, illness, or injury resulting from either performing or not performing any assistance requested.

I am responsible for the delivery of all supplies and will notify the school immediately if we change our medical provider, the procedure changes as written, or the need for these services are terminated.

I agree to submit a revised *Request for Tracheostomy and/or Ventilator Care by School Personnel* (form 5330 F4) if any changes are made regarding the above orders.

I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and school-based health clinic providers as necessary for medical management.

Parent/Guardian signature: _____ Date: _____

Home address: _____ Daytime phone: _____