

SUCTIONING ACTION PLAN

STUDENT _____ D.O.B. _____

SCHOOL _____ TEACHER _____ GRADE _____

PARENT/LEGAL GUARDIAN _____

PHONE: HOME _____ MOBILE _____

Medical Diagnosis _____

Reason for Suctioning _____

Suction Order _____

Nebulizer Order _____

Usual Indications for Suctioning _____

Pulse Oximetry Order/Parameters _____

- Respiratory Distress signs:
- Pulling at clothes
 - Agitation
 - Cyanosis
 - Noisy breathing
 - Respirations Over _____ / Minute

- | | |
|--------------------------|-------------------|
| <input type="checkbox"/> | Suction Machine |
| <input type="checkbox"/> | Connection Tube |
| <input type="checkbox"/> | Bulb Syringe |
| <input type="checkbox"/> | Suction Wall Plug |
| <input type="checkbox"/> | Gloves |

- | | |
|--------------------------|-----------------------------------|
| <input type="checkbox"/> | Suction Tip |
| <input type="checkbox"/> | Suction Catheter _____ French (3) |
| <input type="checkbox"/> | K-Y Jelly |
| <input type="checkbox"/> | Large Plastic Ziplock Bag |
| <input type="checkbox"/> | Small Plastic Bottle of Water |

(Parent will provide supplies/equipment)

Bus Rider _____ Car Rider _____

I, _____, authorize the physician's office to release confidential information about my child.

Parent / Legal Guardian's Signature

Date

Physician's Signature

Date

Physician's Printed Name

Physician's Phone Number