



Colton Joint Unified School District  
Health Services

Parent Consent and Authorized Healthcare Provider Authorization for  
Management of Tracheostomy at School and School-sponsored Events

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| <b>Pupil:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>DOB:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>Date:</b>  |
| <b>School:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>Teacher/Rm:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Grade:</b> |
| <b>Medical office:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Patient Identification #:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |               |
| <b>1. Tracheostomy tube:</b> Type: _____<br>Size: _____<br>Inner cannula <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Clean inner cannula: <input type="checkbox"/> Hydrogen peroxide<br><input type="checkbox"/> Other solution: _____<br><b>2. Tracheostomy dependency</b><br><input type="checkbox"/> Pupil <b>IS</b> trach dependent (no air exchange)<br><input type="checkbox"/> Pupil <b>IS NOT</b> trach dependent (some air exchange)<br><b>3. Tracheostomy suctioning (premeasured)</b> <ul style="list-style-type: none"><li>• Positioning for suctioning: _____</li><li>• Technique: <input type="checkbox"/> Clean <input type="checkbox"/> Modified sterile</li><li>• Frequency: <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____</li><li>• Catheter type/size: _____</li><li>• Sterile saline: <input type="checkbox"/> Not needed<br/><input type="checkbox"/> Thick secretions: amount _____<br/><input type="checkbox"/> Mucus plug: amount _____<br/>Special instructions: _____</li><li>• Suction pressure: _____</li><li>• Additional breaths via resuscitation bag <input type="checkbox"/> No<br/><input type="checkbox"/> Yes; times _____</li><li>• Suction catheter <u>reused</u> after cleaning: <input type="checkbox"/> No<br/><input type="checkbox"/> Yes: _____ number of day(s)<br/>Catheter cleaning procedure: _____</li></ul> | <b>4. Deep tracheal suctioning (performed by licensed healthcare provider):</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes; depth: _____<br><b>5. Stoma care</b> (if needed at school):<br><input type="checkbox"/> Soap & water <input type="checkbox"/> ½ strength hydrogen peroxide<br><b>6. Tracheostomy tube replacement</b> <ul style="list-style-type: none"><li>• Tube size: _____</li><li>• Maximum time allowance for replacing tube: _____</li><li>• Replace tube when:<ul style="list-style-type: none"><li><input type="checkbox"/> tube becomes dislodged</li><li><input type="checkbox"/> unable to clear mucus plug</li><li><input type="checkbox"/> other: _____</li><li><input type="checkbox"/> do not replace tube—action to take: _____</li></ul></li><li>• Use water-soluble lubricant: <input type="checkbox"/> Yes <input type="checkbox"/> No</li></ul> <b>7. Humidification device at school:</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes: Type _____<br>Instructions: _____<br><b>8. Speaking valve:</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes: Type _____<br>Instructions: _____<br><b>9. Medication(s) needed at school:</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes (medication authorization(s) attached)<br><b>10. Other pertinent information or recommendations:</b> |               |

**Authorized Healthcare Provider Authorization for Management of Tracheostomy In School Setting**

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

\*Authorized Healthcare Provider Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

\*Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number \_\_\_\_\_

Supervising Physician Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

☐ I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

**Parent Consent for Authorization and Management of Tracheostomy in School Setting**

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical healthcare service, tracheostomy management, be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Healthcare Plan (IHP).

Parent(s)/Guardian(s) Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

Reviewed by school nurse (signature) \_\_\_\_\_ Date \_\_\_\_\_