DORCHESTER SCHOOL DISTRICT TWO
2026-2027 RESPIRATORY CARE REQUEST FORM

INTERNAL USE ONLY:

- ☐ Supplies Received/Labeled
- ☐ Order Entered into SNAP
- ☐ ICD-10/Billable Time
- ☐ Order Scanned into SNAP
- ☐ Condition Entered
- ☐ IHP Created
- ☐ EAP Created

The following is to be completed by a physician/legal prescriber.

Name of Student: ______________________________ DOB: ______ Grade: ____________

Diagnosis: ____ ICD-10 Code: __________________________

Procedure(s) required while in the school setting (check and complete all sections that apply):

☐ **Tracheostomy Tube:** Trach Size: ___________ mm Trach Length: _________________

Trach Brand: ________________ ☐ cuffless ☐ cuffed with ___________ Secured with: ______________

If decannulation occurs, how long is this student stable until re-insertion can be completed? ___________________

If decannulation occurs, re-insert tracheostomy tube: ☐ yes ☐ no Emergency trach size: ___________ mm

☐ Passy-muir (speaking) valve used at school ☐ Cap trach while at school – frequency: ________________

☐ **Suctioning (check all that apply):** Suction Frequency: ___________ or ☐ PRN

☐ Tracheostomy ☐ Nasal Tracheal ☐ Suction Machine Recommended Depth: _______

Trach Suction Catheter type: ☐ Closed System ☐ Sterile Suction Catheter ☐ Clean Suction Catheter

Use: ☐ Trach Suction Catheter Size: _______ fr -or- ☐ Yankauer Replace: ☐ each use -or- ☐ end of day

☐ Suction with Saline: PRN (thick secretions)

☐ Sterile Saline ☐Non Sterile Saline ☐Trach Toilettes ☐ Amount of saline to use:______ gtts or ml

☐ HME (Humidification Valve) Thermovent - Frequency: ____________________

☐ **Pulse Oxygen Monitoring:** ☐ Continuous ☐ Intermittent – note time(s): __________ ☐ PRN

Treatment parameters for decreased SpO2: ____

☐ **Oxygen Therapy:** ☐ At School ☐ On Bus ☐ PRN

☐ Oxygen Setting: __________________ Does student require Humidified Oxygen: ☐ Yes ☐ No

Oxygen route: ☐ Trach via mask ☐ Trach via T-valve ☐ Nasal cannula ☐ Face mask ☐ Vent

Administer O2 if SpO2 < ______% or the following signs are noted: ___________________________________

☐ **Special Instructions:** ____

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____ _____________________________________ _______________

Signature of Physician/Legal Prescriber Phone Number Date

The following is to be completed by a parent/legal guardian:

1. I request that the above respiratory procedure(s) be administered to my child as ordered by the physician or legal prescriber and hereby release everyone participating in this request from any and all liability associated therewith or stemming therefrom.
2. I understand that additional staff may be trained to assist with the request above.
3. I understand that I am responsible for providing all supplies and equipment necessary for carrying out these orders at school. I understand that the use, replacement, and disposal of all supplies will be done following manufacturer guidelines.
4. I authorize the School Nurse to contact my child's provider for information concerning my child when necessary.

____ _____________________________________

Signature of Parent/Legal Guardian Date