

HEALTH PROVIDER ORDER FOR TRACHEOSTOMY MANAGEMENT

Student's Name:		Date of Birth:	
School:		Grade:	
☐ This order is valid for one (1) year from the date of the provider's signature. ☐ Start date: _____ End date: _____			
HEALTH CARE PROVIDER TO COMPLETE			
Diagnosis or Condition for Treatment:		Allergies:	
<u>Tracheostomy Tube Information:</u> Brand: _____ Size: _____ Length: _____ Type: ☐ cuffed _____ mls saline ☐ non-cuffed			
<u>Tracheostomy Covering:</u> Type/Brand: _____ ☐ capped at all times ☐ capped periodically as follows: _____ ☐ Other: _____			
Humidifier brand/type: _____ Use humidifier as follows: _____			
<u>Pulse Oximetry Monitoring (check all that apply):</u> ☐ PRN for signs/symptoms of respiratory distress ☐ upon arrival to school/bus ☐ prior to dismissal from school/bus ☐ prior to exercise/activity ☐ after exercise/activity ☐ routinely at the following times: _____			
<u>Tracheostomy Suctioning Orders:</u> Suction setting: _____ mmHg Suction catheter size: _____ Fr Depth of suction catheter insertion: _____ mm Suction tracheostomy using clean technique as needed for the following (check all that apply): ☐ visible mucus that cannot be cleared with cough ☐ whistling or gurgling noises ☐ signs/symptoms of respiratory distress ☐ upon student request Routinely suction tracheostomy at the following times or frequency (specify): _____			
<u>Tracheostomy Tube Replacement Orders:</u> In the event of accidental decannulation a nurse may replace the tracheostomy tube with the same size or one size smaller. If a nurse is not able to secure the placement of a new tube within _____ mins. call 911. ☐ Nurse may change tracheostomy ties and gauze as needed when soiled. Other instructions: _____			
Health Care Provider Name (print)		Provider Stamp	
Address:			
Phone:	Fax:		
Health Care Provider Signature:		Date:	
PARENT/GUARDIAN TO COMPLETE			
I authorize School Health personnel and, when appropriate, trained school staff to administer the above-stated medical treatments in accordance with school policies and Maryland State School Health Services Guidelines. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medical treatments at school. I have read the information on the back of this form and assume the responsibilities as stated therein. I understand that at the end of the school year, an adult must pick up the supplies, otherwise it will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.			
Parent/Guardian Name (print):		Date:	
Parent/Guardian Signature:			
Daytime Phone:		Other Phone:	

Order reviewed by the School RN or LPN: _____

Date: _____

TREATMENT GUIDELINES

These guidelines enable school health staff to provide the best possible service to your child.

1. The health provider order form must be completed and signed by the health care provider and the parent/guardian.
2. The parent/guardian is responsible for providing and maintaining all equipment and treatment supplies for the duration of the treatment order.
3. The school nurse or LPN must review and approve the written order prior to administration.
4. Below is a list of common supplies needed for students requiring tracheostomy care.
 - Suction machine and charger
 - Extra tracheostomy tubes in two sizes
 - Caps/Humivents
 - Tracheostomy ties
 - Gauze
 - Saline
 - Suction catheters
 - Suctions canister and tubing
 - Lubricant
 - Gloves