LONG COUNTY SCHOOL HEALTH SERVICES
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR TRACHEOSTOMY CARE

STUDENT INFORMATION

Student's Name _____ **School:** _____

Date of Birth: ____/____/_____ **Age:** _____ **Grade**: _____ **School Year:**_____

☐ **Known drug allergies/reactions If drug allergies, list:** _____

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ **STOP DATE;** _____

Tracheostomy Tube Info.
Brand: _____ * Size: _____ Length: _____
Check all that apply: ☐ Cuff ☐ Non-cuff ☐ Trach Tapes to hold in place
If yes, location of replacement tube: _____
Student will have Emergency Kit/"Go Bag" at school daily.

Humidifier Type:
_____
Required care: _____
_____
_____

Tracheostomy Suctioning Orders:
Suction machine: Set to _____ mm Hg ☐ Will remain at school ☐ Will travel with student back & forth from school
Recommended depth for suctioning: _____ mm
Irrigate with normal saline prior to suctioning? ☐ No ☐ Yes ☐ PRN only Describe circumstance for prn saline w/suctioning: ___
_____.
Written instructions for cleaning machine are to be provided by parent and/or healthcare provider and are to be included in student's Individualized Healthcare Plan.
Suction Technique: ☐ Clean ☐ Sterile Catheter Size: _____ Replace catheter: ☐ Each time suctioned ☐ End of one day
***Is student authorized to complete self-suctioning care?** ☐ Yes ☐ No
If "yes", I hereby affirm that this student has been instructed in proper self-care for suctioning technique.

Unless student is authorized to perform self-care, all tracheostomy suctioning care will be provided by the licensed school nurse.

Tracheostomy Tube Replacement Order in Event of Accidental Decannulation:

I hereby authorize the Licensed School Nurse, who has received training and successfully completed a return skill demonstration, to replace this student's tracheostomy tube with * same size or one size smaller

Is student's breathing assisted via ventilator? Yes ☐ No

If "yes", please provide the following:
Ventilator Brand: _____
Ventilator Settings**:** _____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I understand that additional parent/prescriber authorization forms will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedures. Procedure equipment and/or supplies must be registered with the licensed school nurse or his/her designee.

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

PARENTAL SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the *above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**