Queen Creek
Unified School District

Tracheostomy Order

To be completed by a Licensed Healthcare Provider

Student Name:_____ DOB:_____ Grade:_____ Year:_____

Provider name:_____ Phone Number:_____ Fax Number:_____

Type of Tube:	**Capped:**	**Oxygen:**
_____ ☐ Size:_____ ☐ Date Placed: _____	☐ At all times ☐ Periodically (explain) _____ _____	☐ Required at all times ☐ As Needed (explain):_____ _____

Medical Diagnosis:_____

Students target oxygen saturation level is: _____%

Pulse Oximetry/Nebulizer Treatment:

- **Oxygen saturation should be checked with a pulse oximeter: (check all that apply)**

☐ Before breathing treatment
☐ After breathing treatment
☐ Before Activity
☐ After Activity
☐ Upon arrival/return to school
☐ Prior to departure from school
☐ If signs or symptoms of respiratory distress (blue lips, difficulty breathing, gasping)
☐ Scheduled: _____
☐ Other, please specify: _____

- **Nebulizer Treatment:**

☐ Medication _____ Dose _____ time _____
☐ Medication _____ Dose _____ time _____

Suctioning Instructions: (Please select all that apply)

☐ Suction trach every_____ minutes ☐ Suction trach every _____ hours	Suction trach as needed for: ☐ Choking ☐ Gurgling ☐ Continuous coughing ☐ Upon student request ☐ Other: _____	Saline Installation: ☐ Amount _____ ☐ Frequency _____ Depth to insert catheter_____ Other: _____

When to call EMS:

_____

_____

In the event the trach tube becomes dislodged during the school day:

☐ Call 911
☐ Notify Parent/Guardian
☐ Trained personnel may re-insert per protocol if stoma is well established *After 2 failed attempts EMS will be notified*
☐ Other:_____

Supplies to be brought to school:	
General: ☐ **Extra trach and tie** ☐ **Extra cap, if trach is capped** ☐ **Suction Machine** ☐ **Sterile suction catheter kits** ☐ **Sterile Water** ☐ **Saline Ampoules** ☐ **Other:_____**	**If on oxygen:** ☐ **Extra oxygen tubing** ☐ **Extra oxygen tank** ☐ **Trach mask, if used** ☐ **Other:_____**

I am aware that the parent/ guardian will train the staff/ unlicensed assistive personnel to suction the student

Licensed Healthcare Provider Signature:_____ Date:_____

As the parent/legal guardian I hereby request and authorize the school nurse, health assistant, or other school personnel to administer the medical procedures authorized by the physician named above to the Student. I agree to furnish all equipment, medications, supplies, formulas, or other items necessary for the administration of the services and/or procedures and to provide replacements and maintenance as necessary. I agree to notify the School Health Office immediately if there are any changes in the Student's medical condition or physician's orders that impact the School's responsibilities to the Student or that may impact the Student during the school day. Signing this form shall release the Gilbert Public School District and its employees from liability of any nature that might result from this plan of action. I also acknowledge that trained, unlicensed Gilbert Public School personnel will most likely administer the tracheostomy management and the emergency plan of action.

Parent/Guardian Signature:_____ Phone:_____ Date:_____

Health Aide/Nurse Signature:_____ Date:_____