



School Year: _____

PARENT CONSENT/REQUEST FOR SUCTION/OXYGEN/TRACHEOSTOMY

I give my permission for the school nurse or a staff member trained by the school nurse to perform the following specialized nursing intervention or treatment prescribed by _____ (Physician or Licensed Care Provider) and to contact the Physician regarding any treatment orders, the implementation of the orders, and the outcomes from these treatments. I request that the school continue the intervention or treatment for the duration of the school year or until notified by me or the Physician to change or discontinue. Notice of change must be received in writing. Orders must be renewed annually.

Parent/Guardian Signature

Date

PHYSICIAN'S ORDER FOR SPECIALIZED NURSING INTERVENTION OR TREATMENT

Student Name _____ **Allergies** _____ **Date of Birth** _____

Condition/Diagnosis: _____

Specialized Intervention: **SUCTION** **OXYGEN** **TRACHEOSTOMY**

Suction:

Type of Suction: Oral Nasal Deep Tracheostomy

Method of Suction: Yankauer Catheter Inline Suction Catheter

Catheter: Size: _____ Depth: _____ Time(s)/Frequency: _____

Use of Normal Saline drops: NO YES If Yes: Nose Trach.

Oxygen:

O2 Sat Monitoring: Continuous Spot Check

O2 Sat Parameters: _____

Oxygen Parameters: This student can have up to _____ Liters of O2 via _____

Tracheostomy: Trach Type & Size: _____ Uncuffed Cuffed

If Cuffed Trach, Place: _____ ML of: Sterile Water Air

PMV: YES NO

Any other Precautions, possible side effects, and recommended interventions: _____

Physician name (please print) _____

Address _____ Phone _____ Fax #: _____

Physician Signature: _____ **Date:** _____

*If completed by a nurse practitioner, please indicate the physician in collaborative practice.

Please return by mail or fax to the address or fax # below:

School Name: _____ School Address _____



School Year: _____

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TRACHEOSTOMY**

Phone: _____ Fax: _____ Requesting Nurse: _____