HEALTH SERVICES
Prosper Independent School District

Physician/Parent Authorization for Tracheostomy Care

*This form to be renewed annually and as changes occur.

Student: _____ DOB: ____/____/____ Grade: _____ Date of Plan: ___/____/____

TO BE COMPLETED BY THE PHYSICIAN: Please complete this form based on your examination and knowledge of this student.

Diagnosis or description of condition that indicates need for the tracheostomy:_____

_____

**Please attach a copy of any medical and developmental history that may be pertinent to the therapy program.

TRACHEOSTOMY:

Brand and size: _____ Original date of trach placement: _____

☐ Uncuffed ☐ Cuffed; volume: _____ of: ☐ air ☐ sterile water ☐ Fenestrated

☐ Replace trach if needed with current size or smaller (Routine trach changes will not be done in the school setting)

☐ HME device: prescribed times: _____

☐ Passy-Muir valve: prescribed times: _____

☐ May remain capped. Comments: _____

☐ As needed, clean stoma site with sterile water or _____

☐ Change trach ties if wet/soiled

Other instructions: _____

SUCTIONING: (PISD uses clean technique unless prescribed otherwise)

☐ PRN ☐ Scheduled at: _____ Catheter size:_____ Depth:_____cm Suction Pressure: _____

Catheter type: ☐ Sleeved ☐ Un-sleeved ☐ Yankaur ☐ Bulb Syringe ☐ Other:_____

☐ May use sterile saline ampule prior to suctioning for thick secretions

Other instructions: _____

NEBULIZER:

☐ Routine ☐ PRN ☐ Saline only ☐ Medication: _____

PULSE OXIMETRY MONITORING:

☐ PRN ☐ Once daily ☐ Continuous ☐ Routine frequency: _____

☐ **SUPPLEMENTAL OXYGEN:** If ordered, please complete the *PISD Supplemental Oxygen* form.

☐ **DIETARY RESTRICTIONS:** _____

The parent/guardian is responsible for providing all equipment and supplies necessary for tracheostomy care at school. This includes but is not limited to a suction machine with charger, suction catheters, sterile saline, extra trach ties, 2 different sizes of back-up trach tubes, portable oxygen tank and oxygen, mask, tubing, and pulse oximeter if ordered. Is there any additional equipment that the parent should provide in order to provide this care at school? _____

Physician Name: _____ **Signature**: _____ Date:_____

Clinic/facility: _____ Phone: (_____)_____

TO BE COMPLETED BY THE PARENT/GUARDIAN ----------

I, the undersigned, the parent/guardian of _____ request that the above named specialized healthcare service to be administered to my child. I understand that it is my responsibility to provide the necessary equipment and supplies in order for the prescribed care to be performed at school by district personnel. I understand that the school administration will appoint a qualified designated person to perform the above mentioned healthcare service. It is my understanding that in performance of the service, the designated person(s) will be using a standardized procedure that has been approved by the physician. I will notify the school immediately if the health status of my child changes, I change physicians, or the procedure is canceled or changed in any way. I give my consent to release medical/health records and permission to appropriate school staff to contact the physician/healthcare provider for additional information if needed.

Parent/Guardian Signature: _____ Date _____