

## HEALTH SERVICES

Prosper Independent School District

## Physician/Parent Authorization for Tracheostomy Care

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

Brand and size: Original date of trach placement: Uncuffed	Student:						
"Please attach a copy of any medical and developmental history that may be pertinent to the therapy program.  TRACHEOSTOMY:  Brand and size:							
Brand and size:	Diagnosis or description of condition that indicates need for the	e tracheostor	ny:				
Brand and size:  Original date of trach placement:  Uncuffed	**Please attach a copy of any medical and developmental history that may b	pe pertinent to the	ne thera	py prog	ram.		
Uncuffed   Cuffed; volume:	TRACHEOSTOMY:						
□ 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: □ Passy-Muir valve: prescribed times: □ As needed, clean stoma site with sterile water or □ Change trach ties if wet/soiled Other instructions: □ 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 □ 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: □ Date: □ Clinic/facility: □ Phone: □ Phone: □ Phone: □ Physician Phase Place Prescribed on Phone: □ Physician Phase Place Plac	Brand and size:		Oriai	nal da	te of trach pla	cement:	
□ 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: □   □ All All All All All Served □   □ 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: □   Clinic/facility: □ Phone: ()	☐ Uncuffed ☐ Cuffed; volume: of: ☐ air ☐	□ sterile wat	er				
☐ HME device: prescribed times: ☐ Passy-Muir valve: prescribed times:   ☐ May remain capped. Comments: ☐ Change trach ties if wet/soiled   ☐ Change trach ties if wet/soiled ☐ Change trach ties if wet/soiled   Other instructions: ☐ Depth:				ill not l	oe done in the	school setting)	
□ Passy-Muir valve: prescribed times: □ May remain capped. Comments: □ May remain capped. Comments: □ May remain capped. Comments: □ Change trach ties if wet/soiled   ○ Change trach ties if wet/soiled ○ Change trach ties if wet/soiled ○ Comments of the wet/soiled   ○ 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:	☐ HME device: prescribed times:					<b>.</b> ,	
☐ 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:	☐ Passy-Muir valve: prescribed times:						
☐ 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:   ☐ PRN ☐ Once daily ☐ Continuous ☐ Routine frequency:   ☐ 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: (							
□ Change trach ties if wet/soiled   Other instructions:							
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: Date: Clinic/facility: Phone: ()	_						
□ PRN □ Scheduled at:							
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:  Phone:  Date:  Phone:  Date:  Phone:	,	,			<b>5</b>	0 " 5	
□ May use sterile saline ampule prior to suctioning for thick secretions   Other instructions:   NEBULIZER:   □ Routine □ PRN   □ PRN □ Saline only   □ 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? Signature: Date:   Physician Name: Signature: Date:   Clinic/facility: Phone: ()							
NEBULIZER:   Routine   PRN   Saline only   Medication:   PRN   PRN   Saline only   Medication:   PRN   PRN   Continuous   Routine frequency:   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:   Phone: ()	• •	-	inge	□ Ot	ner:		
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:	·						
□ 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:  Phone: □  Pho	Other instructions:						
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:  Phone:	NEBULIZER:						
□ 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? □ Date: □ Date: □ Date: □ Phone: □ Date: □ Phone: □ Date: □ Da	$\square$ Routine $\square$ PRN $\square$ Saline only $\square$ Medi	cation:					
□ 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? □ Date: □ Date: □ Date: □ Phone: □ Date: □ Phone: □ Date: □ Da	PIII SE OYIMETRY MONITORING:						
□ 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:  Phone:  Phone		onency.					
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:  Phone:  Phone:  Phone:  Date:		•					
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:	·	•					
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: Date: Phone: ()							
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:  Phone: ()					•	•	
should provide in order to provide this care at school?							
Physician Name:							
Clinic/facility:							
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	change physicians, or the procedure is canceled or changed in an	ny way. I give	my co	nsent	to release med		
appropriate school staff to contact the physician/healthcare provider for additional information if needed.	appropriate school staff to contact the physician/healthcare provider	for additional	nforma	ation if	needed.		
Parent/Guardian Signature: Date	Parent/Guardian Signature:				Date		