Mayfield City Schools
EVERY STUDENT. EVERY DAY.

Tracheostomy Care Plan/Orders

The following section must be completed by the PARENT:

School:	Grade:	Year:
Student's Last Name:	First Name:	☐ M ☐ F Date of Birth:

I have read and understand the Mayfield City School guidelines for giving medications. I request authorized school personnel to follow the tracheostomy plan listed below. I agree to see that the medication/supplies are delivered to the school; to notify if there is a change in physicians; to notify if the medication, dosage, or procedure is changed or discontinued. I give my consent to the school nurse to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above.

____/____/______ ________________________________ (______) ______________ (______) ______________
Date Parent/Guardian Signature Home/Cell Phone Emergency Phone

Specifics of Tracheostomy Management

The following section must be completed by the LICENSED PRESCRIBER:

Medical Diagnosis/Specifics:

Type and Size of Trachea Tube: ______________________
☐ Capped at all times
☐ Capped periodically, explain: ______________________
☐ Oxygen required at all times
☐ Oxygen as needed, explain: ______________________
☐ Other: ____

Activity Limitations/Restrictions:
☐ May participate in physical education class if oxygen saturation is over ______________ %.
☐ May participate in outdoor recess if oxygen saturation is over ______________ % and outdoor temperate is above ______________ degrees and below ______________ degrees.
☐ Other, please specify: ____
☐ Notify parent/guardian if temperature is over ____________ °F

Pulse Oximetry/Nebulizer Treatments:
☐ Students normal baseline oxygen saturation is __________ %.
☐ 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 are present (blue lips, difficulty breathing, shortness of breath)
- ☐ Scheduled, please specify times: ____
- ☐ Other, please specify:____

☐ Nebulizer treatment:
- ☐ Medication ________________ ☐ Dose ________________ ☐ Time ________________
- ☐ Medication ________________ ☐ Dose ________________ ☐ Time ________________

Suctioning Instructions:
(please check 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 needed:
- ☐ Amount ______________________
- ☐ Frequency ______________________

☐ Depth to insert catheter ________________
☐ Other: ______________________________

Tracheostomy Emergency Plan

The following section must be completed by the LICENSED PRESCRIBER:

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

- ☐ Call 911
- ☐ Notify parent/guardian
- ☐ School nurse may re-insert per protocol if stoma is well established
- ☐ If oxygen saturation remains between ____ % and ____ % after suctioning and nebulizer treatment, call parent/guardian
- ☐ If oxygen saturation remains below ____ % after suctioning and nebulizer treatment, CALL 911
- ☐ Other: ____

Supplies to be Brought to School:	
General: ☐ Extra trach and tie ☐ Extra cap, if trach is capped ☐ Suction machine ☐ Sterile suctions catheter kits ☐ Sterile water ☐ Saline ampoules ☐ Resuscitation bag ☐ Other: ________________________	**If on oxygen:** ☐ Extra oxygen tubing ☐ Extra oxygen tank ☐ Trach mask, if used ☐ Other: ______________________

(Licensed Prescriber's Stamp)	Licensed Prescriber's Printed Name: ____ Licensed Prescriber's Signature: ____ Date: _____/_____/_______ Telephone Number: (_____) __________________________

Rev 5/22

***Please note a new form is required for every school year**

Gates Mills ● Highland Heights ● Mayfield Heights ● Mayfield Village

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