



# Mayfield City Schools

EVERY STUDENT. EVERY DAY.

## Tracheostomy Care Plan/Orders

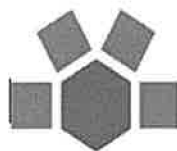
The following section must be completed by the **PARENT**:

School:	Grade:	Year:
Student's Last Name:	First Name:	<input type="checkbox"/> M <input type="checkbox"/> F Date of Birth:
<p>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.</p> <p>____/____/____ (____) (____)</p> <p>Date Parent/Guardian Signature Home/Cell Phone Emergency Phone</p>		

## Specifics of Tracheostomy Management

The following section must be completed by the **LICENSED PRESCRIBER**:

Medical Diagnosis/Specifics:
Type and Size of Trachea Tube: _____ <input type="checkbox"/> Oxygen required at all times <input type="checkbox"/> Capped at all times <input type="checkbox"/> Oxygen as needed, explain: _____ <input type="checkbox"/> Capped periodically, explain: _____ <input type="checkbox"/> Other: _____
Activity Limitations/Restrictions: <input type="checkbox"/> May participate in physical education class if oxygen saturation is over _____ %. <input type="checkbox"/> May participate in outdoor recess if oxygen saturation is over _____ % and outdoor temperature is above _____ degrees and below _____ degrees. <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> Notify parent/guardian if temperature is over _____ °F
Pulse Oximetry/Nebulizer Treatments: <input type="checkbox"/> Students normal baseline oxygen saturation is _____ %. <input type="checkbox"/> Oxygen saturation should be checked with a pulse oximeter: (check all that apply) <input type="checkbox"/> Before breathing treatment <input type="checkbox"/> After breathing treatment <input type="checkbox"/> Before activity <input type="checkbox"/> After activity <input type="checkbox"/> Upon arrival/return to school <input type="checkbox"/> Prior to departure from school <input type="checkbox"/> If signs or symptoms of respiratory distress are present (blue lips, difficulty breathing, shortness of breath) <input type="checkbox"/> Scheduled, please specify times: _____ <input type="checkbox"/> Other, please specify: _____
Nebulizer treatment: _____ <input type="checkbox"/> Medication _____ <input type="checkbox"/> Dose _____ <input type="checkbox"/> Time _____ <input type="checkbox"/> Medication _____ <input type="checkbox"/> Dose _____ <input type="checkbox"/> Time _____



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Suctioning Instructions: ☐ Suction trach *as needed* for:

(please check all that apply)

☐ Choking

☐ Saline installation needed:

☐ Amount \_\_\_\_\_

☐ Suction trach every \_\_\_\_\_ minutes

☐ Gurgling

☐ Frequency \_\_\_\_\_

☐ Continuous coughing

☐ Depth to insert catheter \_\_\_\_\_

☐ Suction trach every \_\_\_\_\_

☐ Upon student request

☐ Other: \_\_\_\_\_

\_\_\_\_\_ hours

☐ 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 suction 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 2-23

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

### SCHOOL FAX NUMBERS

High School Fax: 440-995-6805

Middle School Fax: 440-449-1413

Center Fax: 440-995-7405

Gates Mills Fax: 440-995-7505

Lander Fax: 440-995-7355

Millridge Fax: 440-995-7255

Preschool Fax: 440-995-6805

CEVEC Fax: 440-646-1117

EXCEL TECC Fax: 440-995-675