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: _____ ☐ Oxygen required at all times
☐ Capped at all times ☐ Oxygen as needed, explain: _____
☐ Capped periodically, 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 _____

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Suctioning Instructions: ☐ Suction trach *as needed* for:
(please check all that apply)
☐ Choking
☐ Gurgling
☐ Frequency _____
☐ Continuous coughing
☐ Suction trach every _____ minutes
☐ Suction trach every _____ hours
☐ Upon student request
☐ Other: _____
☐ Saline installation needed:
☐ Amount _____
☐ 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 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