Clarksville-Montgomery County School System

# HEALTH SERVICES

## PARENT/GUARDIAN INPUT – TRACHEOSTOMY MANAGEMENT

*School Year 20____ - 20____*

Student's Name:_____DOB:_____
Parent(s)/Guardian Name:_____
Contact number(s):_____
Parent(s)/Guardian contact phone number(s) during school hours
Physician's Name:_____Phone #:_____

My child has a tracheostomy due to _____
The tracheostomy has been in place since he/she was _____ years old.
Type/size of tracheostomy:_____

Check items below that apply to your child and provide necessary information and physician orders (HEA-F051 – Physician Orders for Tracheostomy Care).
____ Child needs assistance with the daily care of his/her tracheostomy.
____ Child is able to manage most aspects of daily care for his/her tracheostomy, but will need assistance with the following:_____
____ Child is able to manage daily care for his/her tracheostomy independently.

Routine care that will be needed for the tracheostomy during school hours include:
Check all that apply and provide information and physician orders (HEA-F051 – Physician Orders for Tracheostomy Care).
____ Oxygen_____
____ Humidification_____
____ Indications for suctioning_____
____ Suctioning_____
____ Skin/Stoma Care_____
____ Other instructions/comments _____
_____
_____

Instructions for potential emergency situations that may occur with the tracheostomy:
Please put a star (*) next to item if it has occurred within the last year.
__ Mucus plug_____
__ Dislodged tracheostomy (partially out)_____
_____
__Accidental Decannulation (tracheostomy out)_____
_____
_____
__Other_____
_____

****Parents are required to provide all necessary equipment to the school nurse prior to the procedure being performed.****

Parent/Guardian Signature _____ Date _____