Clarksville-Montgomery County School System

HEALTH SERVICES

PHYSICIAN'S ORDERS FOR TRACHEOSTOMY CARE

School year 20____ - 20____

Student _____ School _____ Teacher_____

Diagnosis _____ DOB _____

___Oxygen

_____

___Suctioning by RN / LPN ____Suctioning by student with assistance

Indications/Frequency _____

Type/Size of Catheter _____

Other instructions_____

___Tube displacement or tube is coughed out

Instructions for tube displacement_____

Instruction for tube replacement _____

_____

_____

___Notify parent/guardian ___Notify physician ___Call 911

___Other recommendations for care of student while at school

_____

_____

_____

Additional comments_____

Physician's Signature _____ Date_____

Physician's address_____

Physician's telephone number _____ Fax#_____

PARENT/GUARDIAN PERMISSION FOR RELEASE OF INFORMATION

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

I agree to the release/obtaining of medical information to/from Clarksville-Montgomery County School System. Information will be used to develop an Individual Health Care Plan, as well as to facilitate continuity of treatment for this student. All information obtained will remain confidential. This release is valid for one school year and that school year is listed above.

Parent/Guardian Signature_____Date_____

Witness Signature _____Date_____