PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of Tracheostomy in Educational Settings and Sponsored Events

School Year:

This authorization is valid for the current school year only

Student:	**DOB:**	**Date:**
District/Site:	**Teacher/Rm:**	**Grade:**

1. Tracheostomy tube: Type: _____
Size: _____ Inner cannula ☐ No ☐ Yes
Clean inner cannula with:
☐ Hydrogen peroxide
☐ Other solution: _____

2. Tracheostomy dependency
☐ **Pupil IS trach dependent (no air exchange)**
☐ **Pupil IS NOT trach dependent (some air exchange)**
☐ **May go without trach for _____ minutes**

3. Tracheostomy suctioning (premeasured)
- Positioning for suctioning: _____
- Technique: ☐ Clean ☐ Modified sterile
- Frequency: ☐ PRN ☐ Other: _____
- Catheter type/size: _____
- Sterile saline: ☐ Not needed
  ☐ Thick secretions: amount _____
  Special instructions: _____

Note: Routine use of normal saline prior to suctioning is no longer recommended as an evidenced-based practice.

- Suction pressure: _____
- Additional breaths via resuscitation bag:
  ☐ No ☐ Yes; times _____
- Suction catheter reused after cleaning:
  ☐ No ☐ Yes: _____ number of day(s)
  Catheter cleaning procedure:
- Premeasured suctioning may be performed by unlicensed trained personnel: ☐ Yes ☐ No
  Depth: _____

Oral Suctioning (if needed at school):
Frequency: ☐ PRN ☐ Other: _____
☐ Catheter type/size: _____

Nasal Suctioning (if needed at school):
Frequency: ☐ PRN ☐ Other: _____
☐ Catheter type/size: _____

5. Stoma care (if needed at school):
☐ Soap & tap water / sterile water / NS
☐ ½ strength hydrogen peroxide

6. Deep tracheal suctioning (performed by licensed nurse): ☐ No ☐ Yes - depth: _____

7. Pulse Oximetry
☐ Oxygen Saturations to stay above _____
☐ Oxygen as needed at ____ LPM
☐ Oxygen continuous at _____

8. Tracheostomy tube replacement
- Tube size: _____
  *and one size smaller: _____

Maximum time allowance for replacing tube:
_____ minutes
- Replace tube when:
  ☐ tube becomes dislodged
  ☐ unable to clear mucus plug
  ☐ other: _____
  ☐ do not replace tube—action to take:
- Use water-soluble lubricant: ☐ No ☐ Yes

7. Humidification device at school: ☐ No
☐ Yes: Type _____ Instructions: _____

8. Speaking valve: ☐ No ☐ Yes: Type: _____
Instructions: _____

9. Medication(s) needed at school: ☐ No
☐ Yes (medication authorization(s) attached)

10. Other:
_____
_____
_____
_____
_____
_____

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the credentialed school nurse to communicate with the authorized health-care provider when necessary.

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____