Authorization for Tracheostomy Care

Student Name:___________________________Birthdate:__________________School:_____________ Grade: ______

To Be Completed by a Licensed Health Professional (LHP) with Prescriptive Authority

TRACHEOSTOMY:	☐ **Type:** _______________________________________ **Size:** __________________ ☐ **Artificial nose** ☐ **If trach gets dislodged:** ____	
CARE:	☐ **Bulb Syringe Suction** prn ☐ **Suction and/or irrigate** with saline every _____________ hours ☐ **Suction and/or irrigate** with saline prn ☐ **Ambu Bag prn**	☐ **Clean suction** ☐ **Sterile suction**
	☐ **Oxygen** at ________ liters per trach collar ☐ **Humidification**	☐ **Continuous** ☐ **PRN**
	☐ **Pulse oximeter.** Check every ____________ hours Maintain oxygen saturation between __________________%	
Other Special Considerations		

****Medications to be given at school require completion of an *Authorization for Oral Medications* form.**

I request and authorize that the above named student be provided the above identified treatment in accordance with the instructions indicated above for the period commencing with the _______ day of_____________, 20 ______ through the ____day of _________________ , 20 ___ as there exists a valid health reason which makes provision of the treatment advisable during school hours or during such time that the student is under the supervision of school officials.

___________________________ Signature: ____
Date of Signature (Licensed Health Professional)

Telephone: _________________ Name: ____
(Print or Type)

To Be Completed by the Parent or Legal Guardian

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize Central Valley School District Nursing personnel to provide treatment to the above identified student in accordance with the LHP's instructions for the period commencing with the ___________ day of ______________, 20____. I understand that a new request with physician's orders is to be processed should there be any change in treatment. I will provide the school with the necessary supplies/equipment to perform this service for my child.

Date of Signature: ___________ Signature: _______________________________Telephone Number(s): ______________

Revised 4/2013