Physician Order for Tracheostomy Suctioning

Name of Student:_____ Birth Date:_____

1. The above student is being treated for:
_____

2. Name of procedure: **Tracheostomy Suctioning**

   The parent is required to provide the necessary supplies.

3. Procedure Information:
   Time to be performed_____

   and/or with the following symptoms_____

   _____

   Normal saline is to be instilled. Yes No

   If yes, state amount and specifics _____

   _____

4. This procedure is to be continued as above until:_____
   Date

All authorizations expire at the end of the current school year.

Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.
Please specify a person from your facility who can provide training for school personnel.

Name:_____ Phone:_____
Note: RN may need to contact physician in writing or by phone.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child. I give permission for the RN to contact the physician in writing or by phone.

_____ _____ _____
Signature of Parent/Guardian Phone Date