

Downey Unified School District
Parent Consent and Authorized Healthcare Provider Authorization for
Management of Tracheostomy at School and School-sponsored Events

Pupil:	DOB:	Date:
School:	Teacher/Rm:	Grade:
Medical office:		Patient Identification #:
<p>1. Tracheostomy tube: Type: _____ Size: _____ Inner cannula <input type="checkbox"/> No <input type="checkbox"/> Yes Clean inner cannula: <input type="checkbox"/> Hydrogen peroxide <input type="checkbox"/> Other solution: _____</p> <p>2. Tracheostomy dependency <input type="checkbox"/> Pupil IS trach dependent (no air exchange) <input type="checkbox"/> Pupil IS NOT trach dependent (some air exchange)</p> <p>3. Tracheostomy suctioning (premeasured)</p> <ul style="list-style-type: none"> • Positioning for suctioning: _____ • Technique: <input type="checkbox"/> Clean <input type="checkbox"/> Modified sterile • Frequency: <input type="checkbox"/> PRN <input type="checkbox"/> Other: _____ • Catheter type/size: _____ • Sterile saline: <input type="checkbox"/> Not needed <input type="checkbox"/> Thick secretions: amount _____ <input type="checkbox"/> Mucus plug: amount _____ Special instructions: _____ • Suction pressure: _____ • Additional breaths via resuscitation bag <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes; times _____ • Suction catheter reused after cleaning: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ number of day(s) Catheter cleaning procedure: _____ May perform oral / nasal suctioning if needed. 	<p>4. Deep tracheal suctioning (performed by licensed healthcare provider): <input type="checkbox"/> No <input type="checkbox"/> Yes; depth: _____</p> <p>5. Stoma care (if needed at school): <input type="checkbox"/> Soap & water <input type="checkbox"/> ½ strength hydrogen peroxide</p> <p>6. Tracheostomy tube replacement</p> <ul style="list-style-type: none"> • Tube size: _____ • Maximum time allowance for replacing tube: _____ • Replace tube when: <input type="checkbox"/> tube becomes dislodged <input type="checkbox"/> unable to clear mucus plug <input type="checkbox"/> other: _____ <input type="checkbox"/> do not replace tube—action to take: _____ • Use water-soluble lubricant: <input type="checkbox"/> Yes <input type="checkbox"/> No <p>7. Humidification device at school: <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes: Type _____ Instructions: _____</p> <p>8. Speaking valve: <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes: Type _____ Instructions: _____</p> <p>9. Medication(s) needed at school: <input type="checkbox"/> No <input type="checkbox"/> Yes (medication authorization(s) attached)</p> <p>10. Other pertinent information or recommendations:</p>	
<p>Authorized Healthcare Provider Authorization for Management of Tracheostomy In School Setting</p> <p>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. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.</p> <p>*Authorized Healthcare Provider Name _____ Signature & Stamp _____</p> <p>Date _____ Phone _____ Address _____ City _____ Zip _____</p> <p>*Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number _____</p> <p>Supervising Physician Name _____ Address _____ Phone _____</p> <p><input type="checkbox"/> I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).</p>		
<p>Parent Consent for Authorization and Management of Tracheostomy in School Setting</p> <p>I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical healthcare service, tracheostomy management, be administered to my (our) child in accordance with state laws and regulations. I (we) will:</p> <ol style="list-style-type: none"> 1. provide the necessary supplies and equipment; 2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and 3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization. <p>I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary. I (we) understand that I (we) will be provided a copy of my child's completed Individualized Healthcare Plan (IHP).</p> <p>Parent(s)/Guardian(s) Signature _____ Date _____ _____ Date _____</p>		
<p>Reviewed by school nurse (signature) _____ Date _____</p> <p><input type="checkbox"/> School nurse has informed principal about healthcare services provided for this pupil.</p>		