RISE Learning Center

CONSENT AND REQUEST
FOR AIRWAY MANAGEMENT AND SUPPORT DURING SCHOOL HOURS

This section to be completed by the parent/guardian:

STUDENT: _____ DOB: _____ Teacher: _____

Student's Height: _____ Weight: _____ Hospital of Choice: _____

Parent/Guardian (1st Contact): _____ Phone # (H) _____

(C) _____ (W)_____

Parent/Guardian (2nd Contact): _____ Phone # (H) _____

(C) _____ (W) _____

Alt. Emergency Contact _____ Relation _____ Phone# _____

Physician's Name _____ Phone # _____ Fax# _____

TRACHEOSTOMY INFORMATION

What respiratory complication(s) produce the need for student's trach? _____

When was this diagnosed? _____ Date trach was placed: _____

Trach size and name: _____

Size of emergency trach and where kept: _____

Date trach was removed (if applicable): _____

A tracheostomy is a surgically made opening in the neck (trachea) to allow breathing when the normal pathway is impaired. The opening is held open with a metal or plastic tube, which is tied in place. Tracheal suction is performed to maintain an open airway by keeping it clear of excessive secretions and to stimulate cough.

Suctioning will be performed if signs of obstruction are present by trained personnel:

- According to physician's order.
- Upon request of child
- Noisy, moist respirations occur.
- Respiratory distress exists (restlessness, crying, anxious look, pail or dusky color, chest retractions, nasal flaring and/or labored breathing).
- When mucous is visible at the tracheal opening which the student is unable to clear with a cough.
- If no improvement, 911 will be called and parents notified.

Any additional information you may wish to share: _____

_____

_____

_____

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PRESCRIBER AUTHORIZATION (Applicable sections to be completed by licensed Physician)

STUDENT:_____ DOB: _____

Physician: _____ Physician Phone: _____ Physician Fax: _____

Tracheostomy Tube Info. _____ N/A Humidifier Type: _____

Brand:_____ Size: _____ Length: _____

Check all that apply: _____ Cuff ____Non-cuff _____ Trach Tapes to hold in place Required care: Yes/No

If yes, location of replacement tube:_____
Student will have Emergency Kit "Go Bag" at school daily including ambu bag and adapter.

Oxygen: ☐ N/A ☐ Yes If yes, please note: _____

Route of Administration: ☐ Nasal Cannula ☐ Mask ☐ Ventilator ☐ HME ☐ Other: _____

☐ Continuous @ _____liters per minute

☐ PRN @ _____ liters per minute ***and*** indications/symptoms for administration:_____

_____

Comments/Additional Orders: _____

PRN Airway Suctioning: ☐ N/A ☐ Yes If yes, note: ☐ Oral ☐ Nasal ☐ Tracheostomy

If oral and/or nasal suctioning use: ☐ Yankeur ☐ Fr. Catheter, size:_____ ☐ Sims connector

Indications/symptoms for oral/nasal suctioning: _____

If tracheostomy suctioning needed: Suction catheter size: _____Fr. Depth of suctioning: _____centimeters

Indications/symptoms for tracheostomy suctioning: _____

Saline to be used with tracheostomy suctioning: ☐ No ☐ Yes If yes, note amount: _____

Emergency tracheostomy tube replacement: ☐ No ☐ Yes If yes, note size of tube:_____

Comments/Additional Orders: _____

Ventilator Setting: ☐ N/A ☐ Yes If yes, ….

Respiratory Rate/minute:_____ Title Volume:_____ Pressure Control: _____ PEEP: _____

Inspiratory Time: _____ Pressure Support: _____ Sensitivity:_____

Other: _____

Comments/Additional Orders: _____

Parent/Guardian Signature _____ **Date** _____

Physician's Signature: _____ **Date:**_____

Note: *School will contact emergency personnel if condition warrant and any medical cost incurred are at the expense of the family.
**This form must be completed annually or when changes in settings or procedures are changed.
***Your signature above indicates you are in agreement with this process.