Antelope Valley Union High School District
Tracheostomy Orders

<table>
<tr><td colspan="4" align="center">***** PHYSICIAN SECTION *****
The Authorized Health Care Provider (signing below) must be licensed within the State of California to prescribe medication. (California Education Code 49423 and 49423.6)</td></tr>
<tr><td colspan="2">Student Name</td><td>DOB</td><td>Date Authorized</td></tr>
<tr><td colspan="3">Parent / Guardian Name</td><td>Work / Cell Phone</td></tr>
<tr><td colspan="3">Parent / Guardian Name</td><td>Work / Cell Phone</td></tr>
<tr><td>Type of Tracheostomy Tube</td><td colspan="2">Size</td><td>Artificial nose or humidifying cuff
______ yes ______ no</td></tr>
<tr><td colspan="3">Reinsertion Lubricant</td><td>Known latex allergy
_____ yes _____ no</td></tr>
<tr><td colspan="4">Suctioning Orders
Type of Catheter ________________________________ Size ______________________________
Instill one premixed normal saline dose directly into the tracheostomy tube for irrigation and for the purpose of thinning secretions: _____ prior to every suctioning episode, or _____ as needed
Suctioning times ____ or when student is
1. Unable to clear secretions through coughing when there are no signs of cyanosis or decreased level of consciousness.
2. Exhibiting signs of cyanosis, restlessness or decreased level of consciousness.
3. Has obvious secretions in the tracheostomy tube or at the stoma.</td></tr>
<tr><td colspan="4">If this procedure is required during school hours, these orders will be in effect until July 31st of the summer following the school year for which they are prescribed.</td></tr>
<tr><td colspan="3">Name of Authorized
Health Care Provider</td><td>Signature</td></tr>
<tr><td colspan="3">Address</td><td>Phone</td></tr>
<tr><td colspan="4" align="center">***** PARENT SECTION *****
Initials required # 1, 2 and 3 a or b</td></tr>
<tr><td colspan="4">1. I give my permission as the parent or legal guardian of the above named student to initiate this request to perform suctioning on my child. I acknowledge that a school employee trained by the District Nurse may suction my child. Catheters, tubing, and suction catheter kits that do not have matching information on the written statement and the catheter package, or are not in their original package, will not be accepted or used. All supplies will be counted upon receipt in the health office. All equipment / supplies are the responsibility of the parent. _____ initials</td></tr>
<tr><td colspan="4">2. In order for suctioning to be available to my child at school, I give my permission for the credentialed school nurse to communicate directly with the student’s physician, as may be necessary, regarding the physician’s written statement or any other questions that may arise with regard to suctioning my child. I may terminate my consent for administration of this procedure at school at any time. _____ initials</td></tr>
<tr><td colspan="4">3a. My child has been trained to carry and self-suction and is both responsible and capable of performing this procedure, without assistance or supervision, at school. He / She is also capable and responsible to transport the suction equipment to and from school. I release the district and school personnel from civil liability if my child suffers from an adverse reaction as a result of self-administering this procedure. _____ initials</td></tr>
<tr><td colspan="4">or 3b. I request that my child be assisted and supervised during administration of the suction procedure at school and not be permitted to perform this procedure without proper supervision from school personnel. _____ initials</td></tr>
<tr><td colspan="3">Signature of Parent / Legal Guardian</td><td>Date</td></tr>
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