JONESVILLE COMMUNITY SCHOOLS

INSTRUCTIONS FOR REQUEST FOR ADMINISTRATION OF INDIVIDUALIZED HEALTH CARE PROCEDURES IN SCHOOL – TRACHEOSTOMY CARE

1. This "Request for Administration of Individualized Health Care Procedures in School" is initiated when skilled nursing procedures are deemed necessary to promote the student's health and well being at school.

2. PARENT must complete Sections I and II.

3. PHYSICIAN must complete Section III.

4. When Sections I, II, & III have been completed, PARENT is to return this form to the School Nurse.

GENERAL INSTRUCTIONS

1. Only procedures deemed necessary to promote the student's health and well being will be performed during the school day. Determination will be made by evaluating the student's needs and health status.

2. Upon completion of this request, parent will be requested to send in all supplies and equipment needed to provide the ordered procedure(s). A list of needed supplies and equipment will be given to parents

3. Should there be any significant change in treatment/procedure order(s) by the physician a new form must be completed. This should be sent to school with supplies/equipment needed to perform the procedure(s) in accordance with the new order(s).

4. Any modification in procedure (e.g. amount of tube feeding, time) will require a provider's prescription except on occasions when accommodations are made for off campus activities. The parent should clear these with the physician in advance.

5. This form is good for current school year and must be renewed annually.

REQUEST FOR INDIVIDUALIZED PROCEDURES IN SCHOOL - TRACHEOSTOMY CARE

SCHOOL YEAR_____

CHILD'S NAME (Last, First)	BIRTHDATE	GRADE/TEACHER
ADDRESS	HOME PHONE	WORK/CELL PHONE Mother Father
PHYSICIAN	OFFICE PHONE	EMERGENCY CONTACT/PHONE

I. AUTHORIZATION AND CONSENT FOR SERVICES

I request and authorize the School Nurse to administer individual health care procedures as prescribed by my child's physician. I understand that a new request with physician's orders is to be completed should there be any change in treatment. I will provide the school with the necessary supplies/equipment to perform this care for my child. This authorization will be in effect for the above stated school year.

Parent's Name_____ Parent's Signature _____ Date_____

II. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, school nurse, and the school for effective service provision. This authorization will be in effect for the above stated school year.

Parent's Name_____ Parent's Signature _____ Date_____

III. PHYSICIAN'S REQUEST

Diagnosis:_____ Weight:_____ Height:_____

<table>
<tr><td>Tracheostomy:</td><td colspan="2">❑ Type_____.
❑ Size _____.
❑ Artificial Nose
❑ If trach gets dislodged_____.</td></tr>
<tr><td rowspan="3">Treatment:</td><td colspan="2">Suctioning
❑ with saline ❑ every _____hours
❑ Irrigate with saline every _____hours
❑ Ambu Bag PRN: ❑ Yes ❑ No</td></tr>
<tr><td>❑ Oxygen at _____liters per trach collar
❑ Humidification</td><td>❑ Continuous
❑ PRN</td></tr>
<tr><td colspan="2">❑ Pulse Oximeter: Check every _____hours
❑ Maintain oxygen saturation between_____.%</td></tr>
<tr><td colspan="3">Other Special Considerations:</td></tr>
</table>

PHYSICIAN'S SIGNATURE_____ DATE_____

SCHOOL NURSE REVIEWED_____ DATE_____