Primary Care Provider Authorization: Tracheostomy Suctioning/Replacement

Student: ______________________________ Date of Birth: ______________

School : ______________________________ School Year: ______________

Diagnosis: ____

Type and Size of trachea tube: ____

Suctioning frequency (Check one and fill in):

☐ Every _______ minutes ☐ Every _____________ hours

☐ As needed based upon signs and symptoms as follows:

☐ Choking ☐ Continuous coughing

☐ Gurgling ☐ Upon student's request

☐ Other (Specify): ____

In the event the trach tube becomes dislodged during the school day, may trained school personnel replace it? ☐ Yes ☐ No

**** Latex Allergy:** ☐ Yes ☐ No

Suctioning instructions:

☐ Saline installation needed

☐ Depth to insert catheter: _______________________________

☐ Other (Explain): _______________________________________

Additional health care provider's comments/instructions: _________________________

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_______________________ _______________________
Printed Name of MD, ARNP, or PA Address

_______________________ _______________ __________
Signature of MD, ARNP, or PA Telephone No. Date

***Note to parent/ guardian: signing this form shall release the _______________ School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

_______________________ _______________ __________
Signature of Parent/Guardian Telephone No. Date

_______________________ _______________ __________
Emergency Contact Telephone No. Relationship