Anchorage School District

TRACHEOSTOMY AND/OR VENTILATOR CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

Tracheostomy Tube

Type / Brand: _____ Size: _____

☐ Cuffed ☐ Uncuffed ☐ Fenestrated ☐ Unfenestrated ☐ Other: _____

MEDICAL PROVIDER AUTHORIZATION
(Provider have parent/guardian sign Authorization & Agreement page 2-2)

☐ **Emergency kit / "Go-bag"** (It is the parent/guardian's responsibility to provide supplies and keep the kit updated.)
- ☐ Emergency kit available at school daily ☐ Other: _____

☐ **Utilize a humidification device.**
- Type: _____ Time(s) to be used: _____

☐ **Apply a speaking valve. *ONLY USE A SPEAKING VALVE WHEN A CUFF IS DEFLATED AND/OR FENESTRATED. SPEECH VALVES ONLY LET AIR IN, NOT OUT.**
- Type: _____ When to wear: _____

☐ **Perform tracheostomy tube suctioning.**
- Time(s) to perform suctioning: ☐ As needed ☐ Other: _____
- Suction machine setting: _____ mmHg Recommended suctioning depth: _____ mm
- Suction technique: ☐ Clean ☐ Sterile Catheter Size: _____
- Replace catheter: ☐ After each use ☐ At the end of the day

☐ **Provide tracheostomy tube site care.**
- Time(s) dressing should be changed: _____
- Dressing type: _____ Topical ointment application: _____
- Other: _____

☐ **Replace tracheostomy tube if it becomes dislodged or plugged with the type and size specified above or one size smaller.**

☐ **Monitor ventilator functioning using the following ventilator settings:**
- Mode: _____
- Inspiratory Time: _____ seconds
- Respiratory Rate: _____ breaths per minute
- Tidal Volume: _____ mL
- Pressure support (Above PEEP): _____ cmH2O
- PEEP: _____ cmH2O
- FIO2: ☐ 21% room air ☐ Other: _____
- High Alarm: _____ cmH2O
- Low Alarm: _____ cmH2O

☐ **Administer oxygen.**
- Keep SpO2 greater than: _____ %
- Administer oxygen: _____ liters per minute from portable oxygen tank kept at school
- Administer oxygen using: ☐ Nasal canula ☐ Simple face mask ☐ Partial rebreather mask ☐ Tracheostomy mask or direct connection ☐ Ventilator oxygen adapter and tubing

☐ **Other nursing orders**:

LICENSED MEDICAL PROVIDER IN ALASKA (PRINTED)	TELEPHONE NUMBER
LICENSED MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

I request that the tracheostomy and/or ventilator care outlined on this plan be given to my child. **I will provide needed medications or supplies for care in school.**

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining tracheostomy care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

NURSE PLAN REVIEW AND STAFF TRAINING

I have reviewed the *Tracheostomy and/or Ventilator Care Plan* for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE