Anchorage School District

Tracheostomy and/or Ventilator Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

Student Photo

MEDICAL PROVIDER AUTHORIZATION

EQUIPMENT *(provided by parent/guardian to school nurse)*

☐ Tracheostomy Tube Type _____ Size _____ Cuffed Uncuffed Fenestrated Unfenestrated

☐ Emergency Tube Type _____ Size _____ ☐ Ventilator Model _____

☐ Suction machine ☐ Suction catheter Size _____ ☐ Oxygen tank/supplies ☐ Emergency Go-Bag

☐ HME Type _____ ☐ Speaking valve ☐ Normal saline ☐ Split gauze ☐ Cotton swabs ☐ Ties

TRACHEOSTOMY CARE

☐ Suction settings _____ mmHg ☐ Suction cath size _____ FR ☐ Suction Depth _____ mm

☐ PRN ☐ Scheduled: _____ with ☐ Clean technique ☐ Sterile technique

☐ Loosen secretions with ☐ CPT ☐ Normal Saline

☐ Site care PRN ☐ Site care scheduled: _____ ☐ PRN ointment: _____

☐ Use HME *(time, duration)* _____ ☐ Use speaking valve *(time, duration)* _____

☐ Replace trach if it becomes dislodged or plugged with regular or emergency tube size

VENTILATOR SETTINGS

OXYGEN SUPPORT

Administer oxygen through: ☐ Nasal cannula ☐ Simple face mask ☐ Partial rebreather

☐ Trach mask or directly to trach ☐ Ventilator through oxygen adapter

☐ Keep SpO2 greater than _____ % ☐ Administer oxygen at ____ L/min

OTHER ORDERS

MEDICAL PROVIDER NAME/TITLE	***PHONE NUMBER***	***EMAIL***
MEDICAL PROVIDER SIGNATURE		***DATE***

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

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LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH

PARENT/GUARDIAN AGREEMENT AND 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.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	***RELATIONSHIP TO STUDENT***	***PHONE NUMBER***
PARENT/GUARDIAN SIGNATURE		***DATE***

NURSE PLAN REVIEW

I have reviewed the Enteral Feeding 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	
NURSE SIGNATURE	***DATE***