

Clarksville-Montgomery County School System
HEALTH SERVICES
PARENT/GUARDIAN INPUT – TRACHEOSTOMY MANAGEMENT
School Year 20____ - 20____

Student's Name: _____ DOB: _____

Parent(s)/Guardian Name: _____

Contact number(s): _____

Parent(s)/Guardian contact phone number(s) during school hours (smaller font)

Physician's Name: _____ Phone #: _____

My child has a tracheostomy due to _____.

The trach has been in place since he/she was _____ years old.

Type/size of trach: _____

Check items below that apply to your child and provide necessary information and physician orders (HEA-F051 – Physician Orders for Tracheostomy Care).

____ Child needs assistance with the daily care of his/her trach.

____ Child is able to manage most aspects of daily care for his/her trach, but will need assistance with the following: _____

____ Child is able to manage daily care for his/her trach independently.

Routine care that will be needed for the tracheostomy during school hours include:

Check all that apply and provide information and physician orders (HEA-F051 – Physician Orders for Tracheostomy Care).

____ Oxygen _____

____ Humidification _____

____ Indications for suctioning _____

____ Suctioning _____

____ Skin/Stoma Care _____

____ Other instructions/comments _____

Instructions for potential emergency situations that may occur with the trach:

Please put a star (*) next to item if it has occurred within the last year.

____ Mucus plug _____

____ Dislodged trach (trach partially out) _____

____ Accidental Decannulation (trach out) _____

____ Other _____

Parent/Guardian Signature _____ Date _____