



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

Physician's Name: _____ Phone #: _____

My child has a tracheostomy due to _____

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

Type/size of tracheostomy: _____

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 tracheostomy.

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

___ Child is able to manage daily care for his/her tracheostomy 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 tracheostomy:

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

___ Mucus plug _____

___ Dislodged tracheostomy (partially out) _____

___ Accidental Decannulation (tracheostomy out) _____

___ Other _____

Parent/Guardian Signature _____ Date _____