



Clarksville-Montgomery County School System

HEALTH SERVICES

PHYSICIAN'S ORDERS FOR TRACHEOSTOMY CARE

School year 20\_\_\_\_ - 20\_\_\_\_

Student \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_

Diagnosis \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_ Oxygen \_\_\_\_\_

\_\_\_ Suctioning by RN / LPN \_\_\_\_\_ Suctioning by student with assistance \_\_\_\_\_
Indications/Frequency \_\_\_\_\_
Type/Size of Catheter \_\_\_\_\_
Other instructions \_\_\_\_\_

\_\_\_ Tube displacement or tube is coughed out
Instructions for tube displacement \_\_\_\_\_
Instruction for tube replacement \_\_\_\_\_

\_\_\_ Notify parent/guardian \_\_\_ Notify physician \_\_\_ Call 911

\_\_\_ Other recommendations for care of student while at school \_\_\_\_\_

Additional comments \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's address \_\_\_\_\_

Physician's telephone number \_\_\_\_\_ Fax# \_\_\_\_\_

PARENT/GUARDIAN PERMISSION FOR RELEASE OF INFORMATION

\_\_\_ Release/obtain medical information to/from Clarksville-Montgomery County School System. Information will be used to develop an Individual Health Care Plan, as well as to facilitate continuity of treatment for this student. All information obtained will remain confidential. This release is valid for one school year and that school year is listed above.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_