Office of Student Health Services
Chesterfield County Public Schools

Order for Tracheostomy Management at School

Healthcare Plan/Orders effective for current school year, including summer school.

Revised 7/2025

DOB: _____ **Grade:** _____

Student Name: _____ **School:** _____

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Health Status

Diagnosis:

ICD 10: _____

Tracheostomy:

☐ Type: _____ Size: _____

☐ Artificial Nose PRN: ☐ Yes ☐ No Instructions: _____

☐ Passy-Muir PRN: ☐ Yes ☐ No Instructions: _____

☐ Obturator

If Tracheostomy becomes dislodged, the following procedure(s) will be implemented:

Treatment:

☐ Mechanical Ventilator
(Specific orders, including emergency protocols, MUST be written by LHCP and provided to CCPS before student may attend school)

☐ Suctioning required for the following symptoms: _____

☐ Suction and/or irrigate with saline (amount) _____ every _____ hours

☐ Suction and irrigate PRN: ☐ Yes ☐ No

☐ Catheter size: _____ Suction depth: _____

☐ Ambu Bag *(manual resuscitator)* PRN: ☐ Yes ☐ No

☐ Pulse oximeter: Check every _____ hours and/or PRN: ☐ Yes ☐ No

☐ Maintain oxygen saturation between _____ % and _____ %
(Please define specific oxygen parameters to maintain levels, if O2 is required)

☐ Oxygen at _____ Liters per tracheostomy collar: ☐ *Continuous* ☐ *PRN*

☐ Humidification PRN: ☐ Yes ☐ No ; *Instructions:*_____

If student displays symptoms that cannot be controlled by the treatment methods outlined above—CALL 911 IMMEDIATELY!

This document must be completed in addition to the Individualized Healthcare Plan – General

Licensed Healthcare Provider

_____ _____

Licensed Healthcare Provider Name (Print) / Signature **NPI#** **Phone Number** **Date**

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed and agree to this health plan for my student and understand that school staff /school nurse may communicate with my child's Licensed Healthcare Provider (LHP) regarding this health plan. I acknowledge that I am responsible for providing the school with all medications and supplies required to implement the plan as ordered by the LHP.**

_____ _____ _____ _____

Parent/Guardian Name (Print) **Parent/Guardian (Signature)** **Date** **Phone Number**

_____ _____ _____

School Nurse Name/Signature **Date Received** **Date Emergency Action Plan Distributed**