DORCHESTER SCHOOL DISTRICT TWO
RESPIRATORY CARE REQUEST FORM

The following is to be completed by a physician/legal prescriber.

Name of Student: _____ DOB: _____ Grade/Section: _____

Diagnosis: _____ ICD-10 Code: _____

Procedure(s) required while in the school setting (check and complete all sections that apply):

☐ **Tracheostomy Tube:** Trach Size: _____ mm Trach Length: _____

Trach Brand: _____ ☐ cuffless ☐ cuffed with _____ Secured with: _____

If decannulation occurs, how long is this student stable until re-insertion can be completed? _____

If decannulation occurs, re-insert tracheostomy tube: ☐ yes ☐ no Emergency trach size: _____ mm

☐ Passy-muir (speaking) valve used at school ☐ Cap trach while at school – frequency: _____

☐ **Suctioning (check all that apply):** Suction Frequency: _____ or ☐ PRN

☐ Tracheostomy ☐ Nasal Tracheal ☐ Suction Machine Recommended Depth: _____

Trach Suction Catheter type: ☐ Closed System ☐ Sterile Suction Catheter ☐ Clean Suction Catheter

Use: ☐ Trach Suction Catheter Size: _____ fr -or- ☐ Yankauer Replace: ☐ each use -or- ☐ end of day

☐Suction with Saline: PRN (thick secretions)

☐ Sterile Saline ☐Non Sterile Saline ☐Trach Toilettes ☐ Amount of saline to use:_____ gtts or ml

☐ HME (Humidification Valve) Thermovent - Frequency: _____

☐ **Pulse Oxygen Monitoring:** ☐ Continuous ☐ Intermittent – note time(s): _____☐ PRN

Treatment parameters for decreased SpO2: _____

☐ **Oxygen Therapy:** ☐ At School ☐ On Bus ☐ PRN

☐ Oxygen Setting: _____ Does student require Humidified Oxygen: ☐ Yes ☐ No

Oxygen route: ☐ Trach via mask ☐ Trach via T-valve ☐ Nasal cannula ☐ Face mask ☐ Vent

Administer O2 if SpO2 < _____% or the following signs are noted: _____

☐ **Special Instructions:** _____

_____

_____ _____ _____

Signature of Physician/Legal Prescriber Phone Number Date

The following is to be completed by a parent/legal guardian:

I request the above procedure(s) to be administered to my child as ordered by the physician or legal prescriber and hereby release everyone participating in this request from any and all liability associated therewith or stemming therefrom. I authorize the school nurse to contact my child's provider for information concerning my child when necessary.

_____ _____

Signature of Parent/Legal Guardian Date