Physician Order for
Tracheostomy Suctioning

Name of Student:_____ Birth Date:_____

1. The above student is being treated for:
_____

2. Name of procedure: **Tracheostomy Suctioning**

   The parent is required to provide the necessary supplies.

3. Procedure Information:
   Time to be performed_____

   and/or with the following symptoms_____

   _____

   Normal saline is to be instilled. Yes No

   If yes, state amount and specifics _____

   _____

4. This procedure is to be continued as above until:_____
   Date

All authorizations expire at the end of the current school year.

5. This procedure MUST be performed by licensed personnel **only**. Yes___ no___
   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.
   Please specify a person from your facility who can provide training for school personnel.

Name:_____ Phone:_____
Note: RN may need to contact physician in writing or by phone.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child. I give permission for the RN to contact the physician in writing or by phone.

_____ _____ _____
Signature of Parent/Guardian Phone Date