CUMBERLAND COUNTY SCHOOL
Tracheostomy and/or Ventilator Care Plan

Student First Name: _____ Student Last Name: _____ D.O.B.: _____/_____/_____
School Name: _____ School Year: _____ Grade: _____

Tracheostomy Tube
Type/Brand: _____ Size: _____

☐ Cuffed ☐ Uncuffed ☐ Fenestrated ☐ Unfenestrated ☐ Other: _____

Medical Provider Authorization (Check all that apply)

Emergency Kit/Go Bag
- ☐ Emergency Kit available at school daily
- ☐ Other _____ _____

Utilize a humidification device
- ☐ Type: _____ _____
- ☐ Times to be used: ___ _____ _____

Apply a speaking valve. *Only use when a cuff is deflated and/or fenestrated.*
- ☐ Type: _____ _____
- ☐ When to wear: _____ _____

Perform tracheostomy tube suctioning.
- ☐ Time(s) _____
- ☐ As needed

Suction machine setting: _____ mmHg
Recommended suctioning depth: _____ mm
Suction technique:
- ☐ Clean
- ☐ Sterile

Catheter size: _____
Type of Trach ties: _____
Replace Catheter:
- ☐ After each use
- ☐ At the end of the day
- ☐ Specify time _____

Provide tracheostomy tube site care
- Times dressing should be changed: _____
- Dressing type: ___ _____
- Topical ointment application: _____ _____ _____

Administer oxygen
- ☐ Keep SpO2 greater than: _____%
- ☐ Administer oxygen: _____ liters per minute from portable oxygen tank kept at school

Administer Oxygen using:
- ☐ Nasal capula
- ☐ Simple face mask
- ☐ Partial rebreather mask
- ☐ Tracheostomy mask or direct connection
- ☐ Ventilator oxygen adapter and tubing

Replace tracheostomy tube if it becomes dislodged or plugged with the type and size specified above or one size smaller.

Monitor ventilator functioning using the following ventilator settings:
- Mode: _____
- Inspiratory time: _____ seconds
- Tidal volume: _____mL
- PEEP: _____cmH2O
- High alarm: _____cmH2O
- Respiratory Rate: _____ breaths per minute
- Pressure support (Above PEEP): _____cmH2O
- FIO2: ____ 21% room air Other: _____
- Low alarm: _____ cmH2O

Other nursing orders: _____

Physician's Name: _____
Physician's Signature: _____
Clinic Address: _____
Phone: _____ Fax: _____

Required MD Stamp

Release of Liability *(to be completed by the student's parent or guardian)*

I request that the tracheostomy and/or ventilator care outlined on this form be given to my child. **I will provide needed medications or supplies for care in school.**

I, _____ (Parent/Guardian Name), the parent and/or legal guardian of _____ (Student Name), enrolled at _____ (School Name), understanding the importance of administering medication as prescribed by my child's physician, hereby agree to release and hold harmless designated school personnel from any liability related to the administration of medication, including injections, to my child. I acknowledge that I have discussed this matter with my physician and/or legal counsel, and fully understand the potential ramifications of this consent. I grant permission for the medical provider to disclose necessary health or medical information regarding the prescribed medication to the school personnel involved in its administration. I understand that I have the right to revoke this consent at any time, except where actions have already been taken based on this consent. This consent remains valid for one year or until I revoke it in writing, whichever occurs first.

Parent or Legal Guardian Signature: _____ Date: _____/_____/_____

Nurse Signature: _____ Date: _____/_____/_____