Houston Independent School District
Health and Medical Services

Physician Orders for Respiratory Care

To the Principal of: _____

Child's Name: _____ Date of Birth: _____

Diagnosis: _____ Latex Allergy Present: ☐ Yes ☐ No

Etiology _____ Prognosis _____ Date of Onset _____

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

☐ Tracheostomy Tube:

Trach Brand: _____ ☐ cuffless ☐ cuffed with _____ cc air or H2O

Trach Size: _____ mm Emergency trach size: _____

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

If decannulation occurs, re-insert tracheostomy tube: ☐ Yes ☐ No

☐ Suctioning while at school (check all that apply):

☐ Tracheostomy ☐ Nasal Tracheal – Depth: _____

Trach Brand: _____ ☐ cuffless ☐ cuffed with _____ cc air or H2O

Trach Size: _____ mm Use: ☐ Trach Suction Catheter Size: _____ fr ☐ Yankauer

Suction frequency: _____ q hrs or PRN ☐

Suction with saline: PRN (thick secretions) Amount of saline to use: _____ gtts or ml

Passy-muir (speaking) valve use at school: ☐ Yes ☐ No

Cap trach while at school: ☐ Yes ☐ No Frequency: _____

HME (Humidification valve) Thermovent ☐ Yes ☐ No Frequency: _____

☐ Ventilator:

Ventilator at home: ☐ Yes ☐ No ☐ PRN Ventilator at school: ☐ Yes ☐ No ☐ PRN

Amount of time permitted off ventilator: _____

Ventilator Brand: _____

Ventilator Settings:

If SPO2 is less than _____ % or respirations are > _____ bpm or signs of respiratory distress then

Suction, if no improvement connect to the ventilator with the following settings:

Mode: _____ Rate_____ TV_____ iT _____ PS _____ PEEP_____ Low Minute Volume Alarm _____

High Pressure _____ Low Pressure _____ Sensitivity _____

☐ Pulse Oxygen Monitoring: ☐ Continuous ☐ Intermittent ☐ PRN

If Intermitte how often: _____

Treatment parameters for decreased SpO2: _____

☐ Oxygen: _____

Needed at school: ☐ Yes ☐ No ☐ PRN

Needed on the bus: ☐ Yes ☐ No ☐ PRN

Oxygen route: ☐ Trach via mask ☐ trach via T-valve ☐ nasal canula ☐ face mask ☐ vent

Oxygen setting: _____ LPM

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

☐ Nebulizer Treatment at school: ☐ Yes ☐ No ☐ PRN

Delivery route: ☐ face mask ☐ trach mask ☐ trach valve ☐ blowby

Give _____ q _____ hrs x _____ days/ongoing

Special instructions: (Include precautions, possible reactions and interventions) A registered nurse will coordinate the health care of all students, including medications, treatments, and prescribed procedures.

_____

_____ _____ _____

SIGNATURE OF PHYSICIAN TELEPHONE DATE

I request the above procedure(s) be administered to my child as ordered by the physician. I authorize the school nurse to contact my child's physician for information concerning my child when necessary.

_____ _____ _____

SIGNATURE OF PARENT TELEPHONE DATE Rev. 7/11 GJ:slr