AUSTIN Independent School District | Health Services and Nursing

Authorization for Administration of Special Procedures

The School RN will review the order & ensure that it is completed & dated. Specialized health care will be provided when this form is completed in its entirety by both physician(s) & parents/guardians and supplies are provided. Form must be renewed annually. Procedures may be delegated to trained AISD staff.

Student Name _____ DOB_____ School ID_____

Condition/Diagnosis: _____

The procedure(s) is required for student while in the school setting (check all that apply):

Urinary Catheterization: ☐ Straight Catheterize ☐ Self Catheterize ☐ Other_____
Size _____ Every ____ hours ☐ Measure urine output, notify parent if greater than _____mL.

If unable to pass catheter, parent will be notified immediately. All care is provided with clean technique.

Diaper Change: ☐ PRN ☐ Scheduled: _____AM/PM _____AM/PM_____AM/PM
☐ Apply _____ to skin PRN redness

Blood Pressure Monitoring: Frequency _____ Duration _____
If BP is greater than _____/_____ or less than _____/_____, inform MD and parent/guardian.
Position ☐ Sitting ☐ Standing ☐ Lying ☐ Other_____

Oxygen Monitoring and Administration: Baseline O2 saturation is _____% via pulse oximeter.
Scheduled pulse oximeter monitoring: _____AM/PM _____AM/PM _____AM/PM
If SpO2 is below _____% notify parent, if SpO2 is below _____% activate EMS.
Give _____ liters per minute ☐ continuous ☐ PRN for_____
via ☐ nasal cannula ☐ simple face mask ☐ tracheostomy collar

Oral Suctioning: Oral suction PRN via Yankauer at _____mmHg / ☐ High ☐ Medium ☐ Low
for ☐ Thick secretions ☐ Visible drooling ☐ Suspected aspiration ☐ Other _____

Tracheostomy Care and Management: All care is performed using clean technique.
Type _____ Size_____ ☐ Uncuffed ☐ Cuffed ____mLs
☐ Capped at all times ☐ Capped periodically as follows_____ ☐ Other_____
Suction catheter size _____ depth _____cm / In-line catheter depth _____cm
Frequency of suction ☐ PRN visible/audible secretions ☐ PRN inability to cough/clear secretions
at _____mmHg/ ☐ High ☐ Medium ☐ Low
Saline with suctioning ☐ No ☐ Yes: _____drops ☐ Prior to suctioning ☐ PRN thick secretions
Solution for suction catheter lubrication/rising ☐ Tap water ☐ Sterile water ☐ Saline
Suction catheter reuse ☐ Yes if clean ☐ Use a new (sterile) catheter for each suction episode
☐ Change gauze tracheostomy dressing PRN if wet or soiled.

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All supplies must be provided by parent/guardian and available each day:

- Bag-valve mask with trach fitting
- Obturator
- Spare trach cannula of current size
- Spare trach cannula of smaller size
- Spare trach ties
- Suction machine (clean)
- Suction catheters (2 minimum)
- Gauze dressing
- Manual suction in case of mechanical failure (bulb)
- Spare trach fitting (cap, Heat Moisture Exchange nose, etc)

Accidental decannulation/dislodgement of a tracheostomy at school is an emergency. Staff should remain with the student at all times and immediately activate EMS if respiratory distress occurs. If decannulation occurs, and the student remains stable proceed as follows:

☐ Activate EMS immediately and remain with student.

☐ Student is able to tolerate decannulation for _____ while attempting recannulation. If recannulation is not achieved in this time, or if student becomes unstable, activate EMS.

☐ RN, trained staff, or parent/guardian may attempt reinsertion with obturator if cannula is not soiled or with a new cannula with obturator. If recannulation is not achieved, reposition and re-attempt. If still unsuccessful, attempt to place smaller cannula.

☐ Student is able to remain at school after recannulation with notification to parent/guardian.

☐ Student to be picked up from school after recannulation for immediate provider follow-up.

☐ Other_____

Other procedure (Describe, specify frequency and indication):

_____

_____

_____

_____

_____ _____

Medical provider signature | Printed name/stamp

_____ _____ _____

Direct clinical phone | Fax | Date

We (I), the undersigned, parent(s)/guardian(s) of _____ request the above
Student's Name

procedure be administered to our(my) child. We (I) authorize the School Nurse to contact our (my) child's physician(s) for further information concerning my child when necessary. We will notify the school immediately if the health status of our child changes, we change physicians or there is a change or cancellation of the procedure.

_____ _____

Parent/guardian signature | Printed name

_____ _____ _____

Daytime phone | Alternative phone | Date