TRACHEOSTOMY SUCTIONING PERMISSION FORM

HEALTH SERVICES
SCHOOL DISTRICT U-46

PARENT PERMISSION: Please PRINT information: School Year: _____

Student Name: _____ Date of Birth: _____
Last Name,First Name Month Day Year

Address: _____
House Number / Street Apt # if necessary City ZIP

School: _____ Grade:_____ Teacher: _____
Name of School Teacher's Name

☐ I give my permission for the above named student to be suctioned at school by the nurse.

☐ I give permission for the nurse to communicate as warranted with the physician or hospital regarding my student's health concerns. A copy of this permission is as valid as the original

Printed Name: _____ Home Phone: _____ Work Phone:_____
Parent/Guardian printed name area code + number area code + number

Signature: _____ Date of signature:_____
Signature of Parent/Guardian Month Day Year

PHYSICIAN ORDERS:

☐ I request that the nurse suction the above named student at school.

☐ The student should be routinely suctioned every _____ hours during the school day.
Number of Hours

☐ The student should be suctioned as needed during the school day.

Tracheostomy Type: _____ Size: _____

Other special instructions include:

_____

_____

Signature: _____ Date of signature:_____
Signature of Physician Month Day Year

Physician's Printed Name: _____
Physician's printed name Medical Group/Clinic

Office Address: _____
Street Address Suite # if necessary City ZIP

Office Phone: _____ Fax Number: _____
area code + number area code + number

Please return completed form to School Health Office