ONTARIO-MONTCLAIR SCHOOL DISTRICT
Health Services
PARENT REQUEST PROCEDURE for SUCTIONING AND CHANGE OF TRACHEOSTOMY

School Phone # _____

School Fax # _____

This form must be completed before any procedure can be given, or taken, at school.
Signatures of both physician and parent/guardian are required. This form must be renewed annually or with any change in order.

Student Name: _____ Date of Birth _____

Diagnosis: _____

PHYSICIAN USE ONLY

☐ May suction tracheostomy AS NEEDED (PRN)

Size of catheter to be used _____ french.

☐ May lavage tracheostomy with 3 – 4 drops of Normal Saline as needed for thick secretions.

☐ May change tracheostomy as needed for dislodgement/malfunction using aseptic technique.

☐ Tracheostomy size Shiley # _____ Other: _____