Form 33 - 05/2015

LOS ANGELES UNIFIED SCHOOL DISTRICT
District Nursing Services

CARE PLAN FOR STUDENT WITH TRACHEOSTOMY

School Year _____

Name _____ (Last), _____ (First) Grade_____ ID Number _____ _____

School _____ Teacher _____ Homeroom _____

Emergency contact:

Mother/Guardian _____ Work Phone _____ Home Phone _____ Cell _____

Father/Guardian _____ Work Phone _____ Home Phone _____ Cell _____

Other _____ Work Phone _____ Home Phone _____ Cell_____

Licensed Healthcare Provider_____ Phone _____

DIAGNOSIS _____ **TRACHEOSTOMY** for_____

Degree of Dependency: _____

Tracheostomy Tube:_____ Size:_____

☐ uses speaking valve length of time_____hours ☐ all day

☐ Trach Tube is capped length of time_____hours ☐ all day

**Supplies should be immediately available at all times during school day, district provided transportation and school sponsored activities

Suctioning: ☐ PRN

Signs that suctioning is needed: moist gurgling noises, whistling sounds, mucus seen at trach opening

Usual frequency of suctioning:_____

☐ Student is able to request suctioning.

Coverage for HCA breaks and lunch:

☐ student in classroom: HCA checks student for possible need for suctioning before leaving and is available by: ☐ intercom ☐ walkie talkie ☐ cell

☐ coverage provided :_____

Problems that Require Immediate Attention:

Signs of respiratory distress: *difficulty breathing and/or cyanosis (bluish color)*: suction

Blocked trach tube, probably from mucus plug *(suction catheter will not pass, no air exchange)*: remove and replace trach tube

Trach tube dislodges: replace trach tube

Aspiration of foreign material into trach *(sand, food, water)*: suction, **DO NOT** use manual resuscitation bag.

Call 911

Plan prepared by School Nurse _____ _____
Signature Date

Plan reviewed by Parent/Guardian _____ _____
Signature Date

Copy of Plan to: ☐ Teacher/Sub Folder ☐ Administrator ☐ HCA ☐ Health Record _____
Date