Houston Independent School District
Health and Medical Services

Physician Orders for Respiratory Care

To the Nurse of: _____School Student ID Number: _____
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):**
☐Tracheal-Depth _____ ☐Nasal-Depth _____ ☐Oral-Depth_____
Trach Suction Catheter Size: _____fr ☐Yankauer
Suction frequency: Every _____ hours ☐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 Intermittent, 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**