SIDNEY CITY SCHOOLS

750 S. FOURTH AVENUE
SIDNEY, OHIO 45365
MAIN: 937-497-2200
FAX: 937-497-2211

To inspire, empower, and prepare our students for their best future.

TRACHEOSTOMY ACTION PLAN

(2 pages)

Student's Name: _____ Date of Birth: _____

Address: _____

Street City State Zip Code

Parent/Guardian's Name: _____ Phone: _____

Physician's name: _____ Physician's phone: _____

According to our records you have informed the school that your child has a tracheostomy in place. Please complete the information below. This will help school staff to know more about how your child reacts to his/her medical condition and the best way to protect the health and safety of your child while at school. All supplies needed for routine care must be provided by parent/guardian.

Type and Size of Trachea Tube: _____

Latex allergy: _____yes _____no

Suctioning Frequency: _____minutes/hours

As needed based upon the following symptoms:

_____ choking _____continuous coughing _____gurgling _____upon student request

_____other (specify) _____

Suctioning Instructions:

_____ saline installation needed _____ depth to insert catheter _____suction catheter size

_____ other (explain) _____

How often does your child's tracheostomy become dislodged? _____

In the event the tracheostomy tube becomes dislodged during the school day, may trained school personnel replace it? _____ yes _____ no

Please note that if the tracheostomy tube is replaced a parent/guardian will be notified. If after 2 attempts to replace with no success EMS will be called and parent/guardian will be notified. The student will be transported to an emergency facility or released to parent/guardian after signing the EMS release form.

EMERGENCY PLAN OF ACTION

1. If student's color becomes pale, cyanotic (bluish), or ashen OR student has other signs of respiratory distress (difficulty breathing, gasping, etc) call EMS.

2. If tracheostomy tube becomes dislodged and replacement is unsuccessful by trained personnel, EMS will be called and parent/guardian will be notified.

3. CPR will be initiated if needed prior to EMS arrival.

4. If student is transported via EMS, a staff member must ride with the student unless parent/guardian or emergency contact accompanies them.

5. If student requires medical treatment while on the bus, the driver will contact EMS.

6. Other _____

Please list in order the names and phone numbers of the people to contact in the event a parent/guardian is unable to be reached in the event of an emergency.

1. Name:_____ Relationship: _____ Number:_____

2. Name:_____ Relationship: _____ Number:_____

3. Name:_____ Relationship: _____ Number:_____

Please contact the public health/school nurse if you have any questions or if your child's medical condition changes during the school year. Thank you for your cooperation and help in providing the best care for your child.

_____

Parent/Guardian's Signature Date