Chandler Unified School District #80

Suctioning Care Plan and Order for Prescribed Services

Student Name: _____ DOB: _____

School: _____ Grade: _____ Date: _____

To Be Completed by Health Care Provider:

Student's medical diagnosis: _____

Indications for Suctioning: _____

Suctioning Type: ☐ Oral

☐ Nasal (must be performed by nurse) ☐ Trach (must be performed by nurse)

Suction when student's oxygen saturation level is: _____

Target oxygen saturation level is: _____

Notify Parents: _____

Call EMS: _____

Other recommendations: _____

Date to be discontinued: _____

Licensed Health Care Provider Acknowledgement: I am aware that the parent/guardian in conjunction with the school/district licensed registered nurse will train the staff/unlicensed assistive personnel to perform this procedure while the student attends school. **Standards of care available upon request*

Licensed Healthcare Provider Name: _____ Phone No. _____
(print)

_____
Licensed Healthcare Provider Signature *Date*

Parent Acknowledgment: I agree with the above care plan and to provide necessary equipment/supplies properly labeled for use in school. I will work in conjunction with the school/district licensed registered nurse to train the staff/ unlicensed assistive personnel to administer the above procedure. If the procedure changes, written verification from your licensed health care provider is required. I grant permission for the registered nurse to communicate directly with the above-named provider, regarding any questions or concerns regarding this procedure or health related issues. I will notify the school of changes in procedure or provider.

Parent/Guardian Name: _____ Phone No. _____

Parent/Guardian Signature: _____ Date: _____