Cherokee County School District

TRACHEOSTOMY ACTION PLAN

STUDENT_____ D.O.B._____

SCHOOL_____ TEACHER_____ GRADE_____

PARENT/LEGAL GUARDIAN_____

PHONE: HOME_____ MOBILE_____

Medical Diagnosis _____

Reason for Trach._____

Nebulizer Order_____

Suction Orders_____

Lavage Orders_____

Pulse Oximetry Order/Parameters_____

ROUTINE TRACHEOSTOMY CARE WILL BE DONE AT HOME.

Go bag complete: _____ Yes (PARENT RESPONSIBILITY)

Supplies contained in Go bag:

_____

Personnel who should be trained in emergency trach. care:

_____

Car Rider _____ Bus Rider _____ Bus Number _____

I,_____, authorize the physician's office to release confidential information about my child.

_____ _____

Parent/Legal Guardian's Signature Date

_____ _____

Physician's Signature Date

_____ _____

Physician's Printed Name Physician's Phone Number