RACINE UNIFIED SCHOOL DISTRICT
Health Services
Mechanical Suctioning at School

PARENT/GUARDIAN REQUEST:

Student's Name:____ Date of Birth:____________________
Please Print

Parent/Guardian's Name:_____________________________________ Date Requested:__________________

I request that my child, named above, receive the following procedure at school using the doctor's orders written below. I give permission for the school nurse to contact the doctor or the doctor's representative to clarify any questions about the procedure. I understand that this procedure requires a new order each school year or if there is any change. I understand that I am responsible for providing all supplies related to this procedure.

Procedure: ☐ **Oral suctioning** ☐ **Pharyngeal suctioning** **Latex Allergy:** ☐ YES ☐ NO

Parent/Guardian's Signature:____

PHYSICIAN'S ORDERS:

Student's Name:_____________________________________ Date of Birth:______________________

Physician's Name:___________________________________ Phone Number:_____________________

Address:____ Fax Number:_______________________

I authorize that the student named above receives mechanical at school per the orders below. I understand that a school district employee(s) trained by the school nurse following school district protocols will perform or assist with the procedure as needed.

Length of Order: ☐ Full School Year/Summer School ☐ From________________to________________

Procedure is: ☐ Oral suctioning ☐ Pharyngeal suctioning ☐ Both

Latex Precautions: ☐ Yes ☐ No

Reason for need for suctioning:____

Type and size of suction catheter:____

Frequency of suctioning:____

I want to be notified if:____

____

Does this order replace a previous order: ☐ No ☐ Yes If yes, the previous order will be discontinued.

Comments:____

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Physician's Signature:____ **Date**:__________________