Central Kitsap School District
Health Services
PO Box 8, Silverdale, WA 98383
360-662-1070 / Fax 1-360-633-1688

Provider Order for Suctioning at School

Student Name _____ DOB _____

School _____ Grade _____ School Year _____

TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER WITH PRESCRIPTIVE AUTHORITY

Diagnosis _____

Indications for suctioning _____

_____

_____

Position required during suctioning _____

Equipment needed (to be provided by parent/guardian)

- ❑ Portable suction machine (including charge cord and apparatus)
- ❑ Suction catheter(s) type: ❑ in-line ❑ disposable
- ❑ Normal saline solution
- ❑ Bulb syringe
- ❑ Nasal suction apparatus

For students with tracheostomy:

Trach size _____ Trach brand _____

Suction catheter size (French) _____

Safe suction depth _____ For in-line (color in the "window") _____

Other instructions _____

_____

_____

Duration of order is for current school year unless otherwise noted _____

Provider's Signature _____ Date _____

Printed Name _____ Phone _____

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

As the parent/legal guardian of this child, I request this treatment be provided as written and I understand that:

- This treatment will not begin until adequate training of qualified staff is completed.
- I must provide all necessary supplies and equipment to perform this service.
- I must notify the school about any changes or cancellations.
- Any supplies left at school after the end of the school year will be discarded.
- The school accepts no liability for untoward reactions when the treatment is administered in accordance with directions.
- My signature allows the school nurse to discuss this medical condition/order with the provider.

Parent/ Legal Guardian Signature _____ Date _____

Printed Name _____ Phone _____