Kauri Sue Hamilton School
2827 W 13400 S Riverton, Ut 84065
801-567-8500 Fax- 801-567-8522
kshs.nurses-uc@jordandistrict.org

Physician Orders For Direct Care Nursing

*** All medications, treatments, procedures and emergency care will be performed by the student's licensed direct care nurse. During an emergency response, Kauri Sue Hamilton School nurses may intervene and perform care as needed.***

Student Name: _____ DOB: _____
Parent/Guardian:_____ Phone:_____

Diagnoses:_____

_____

Allergies and Reaction: _____

_____ This student has a tracheostomy and requires direct nursing supervision for airway maintenance.
_____ This student requires direct nursing supervision due to the above diagnoses and requires direct care nursing for: _____

Respiratory Care:

Tracheostomy Type and Size:_____ Cuffed with _____ml air

Not cuffed:_____ HME:___Y / N____ Trach Cap:___Y / N____

***If decannulation occurs, the nurse will reinsert immediately unless otherwise indicated.**

Suctioning Orders while at school: (check all that apply)

- ❑ Nasal/ Oral
- ❑ Oral tracheal (no tracheostomy) Depth_____
- ❑ Tracheostomy closed suction_____ open suction_____ Depth_____
- ❑ Suction with saline ___**Y / N**_____ Amount_____ PRN_____

Ventilator (If applicable): Cough Assist: __**Y / N**____ Settings:_____
Vent Settings: Mode_____ Rate_____ TV_____ PS_____ PEEP_____
High Pressure_____ Low Pressure_____ Sensitvity_____
Pulse Oximetry Monitoring: Continuous_____ PRN_____
Oxygen use: _____L/min via _____ continuous _____PRN if O2 sats below 90%

Medications to be administered during school hours: (School is dismissed at 2pm)

Medication:_____ Dose:_____ Route:_____Time:_____
Instructions if PRN:_____
Medication:_____ Dose:_____ Route:_____Time:_____
Instructions if PRN:_____
Medication:_____ Dose:_____ Route:_____Time:_____
Instructions if PRN:_____

Emergency/Rescue Medication- include specific instructions:

_____

_____

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Other Treatments:

_____

_____

Feeding Orders:

G-Tube_____ G-JTube_____ GT button type and size:
Brand:_____ Size: _____ F _____ cm _____(ml) volume of water in balloon
Formula name:_____ Water only:_____

Bolus feeding via syringe or bag (gravity)

Volume (amount):_____ml over _____ minutes
Feeding is required every _____ hours ***-OR-***
Feeding is required at _____ o'clock (and) _____ o'clock ***-OR-***
Feeding is required ONLY if student does not eat lunch orally
Flush before and after with _____ml water

Feeding Pump- *Pump to be programmed by parent/care center*

Bolus Pump Feeding: Volume (amount)_____ml Rate set at: _____ml/hr over _____minutes
Continuous Pump Feeding: Rate set at: _____ml/hr

Additional Water:

Volume (amount):_____ml Administer via ▢ GT ▢ JT ▢ Gravity ▢ Pump -Rate set at: _____ml/hr over _____minutes

Student may also eat orally: Yes/No:_____

If yes, texture (regular, chopped, soft, puree) or diet restrictions_____

Tastes Only: _____ **NOTHING** by mouth: _____

Aquatic Therapy: The pool at Kauri Sue Hamilton School is heated to 93 degrees. It is 0 to 5 feet deep and equipped with accessible lifts and pool gurneys. Multiple types of floatation devices are also available. Students with tracheostomies will be one on one with Kauri Sue Hamilton staff or their direct care nurse while in the pool. It is required that their tracheostomy be capped to avoid pool water from entering the stoma. Students that are ventilator or oxygen dependent, who cannot tolerate the duration of pool time without these assistive devices/ therapy, will not swim for safety purposes. Tracheostomies will not be submerged under water at any time.

_____**Is medically stable** to participate in Aquatic Therapy (May Swim)

_____**Is medically contraindicated from** participating in Aquatic Therapy (Cannot Swim)

Does the student have a POLST or DNR order?_____ If yes, please provide a copy for the nursing department.

Parent/Guardian Signature _____ Date: _____

Doctor's Name: _____ Date: _____

Doctor's Signature: _____ Phone: _____

(This order must be signed by a physician, nurse practitioner, or physician assistant.)