Kauri Sue Hamilton School
2827 W 13400 S Riverton, Ut 84065
801-567-8500 Fax- 801-567-8522

Physician Orders For Direct Care Nursing

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 above diagnoses and:

____

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 Amount_______ PRN________

Ventilator (If applicable):

Vent Settings: Mode________ Rate_________ TV________ PS________ PEEP__________

High Pressure_______ Low Pressure_________ Sensitvity_________

Pulse Oximetry Monitoring: Continuous_________ PRN__________

Oxygen use: _____L/min via __________ continuous *or* _____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:____________________

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Route:________Time:____________ Instructions if PRN:______________________________

Emergency/Rescue Medication- include specific instructions:

____

____

Other Special Treatments:

____

____

Feeding Orders:

PO diet order (if applicable): ______________________ Texture:___________________
G/J Tube: Formula: ________________________ Amount of Formula _________mL
Additional water (flush) ________ mL before and/or ______ mL after feeding
Administering feeding by: syringe bolus ______, feeding bag (by gravity)_______
or feeding pump____ Continuous_____ Intermittent_____ set at ______ ml/hr x ____hr(s)
Feeding is required every ______hours (or) at ______o'clock and ____o'clock
or _____ only if a student does not eat lunch.
Need to check for determination of gastric residuals? yes____ no____ .
If more than _____cc of gastric residual, withhold the feeding for 30-45 minutes and then recheck for residual.
GT button type and size:-_ Brand:________________ Size: ________ F _____ cm
_______(ml) volume of water in balloon

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