PHYSICIAN ORDER FOR SCHOOL INTERMITTENT CATHETERIZATION

Student Name: ___________________________ DOB: __________________
School: ___________________ Grade: ______ Grade School Year: ________________

This Section to be Completed by PHYSICIAN:

Allergies: ______________________________________________________________________
Medical Diagnosis: ______________________________________________________________________
Catheterization Order: (check applicable box)

☐ Intermittent Catheterization by School Nurse/Trained School Staff
☐ Intermittent Catheterization by Student (Self-Cath)
☐ Assistance or Monitoring Needed with Self-Cath

Frequency During the School Day:

☐ Every ________ hours
☐ Specific Times as listed: ________ ________ ________ ________ ________

Output needs to be measured each time: ☐ Yes ☐ No

Additional Information about this procedure:
______________________________________________________________________________

In order to keep this child in optimum health and to help maintain school performance, it is necessary that this procedure be administered during school hours.

______________________________ __________________
Physician’s Signature Date

______________________________ ( ) __________________ ( )
Physician’s name (print) Telephone Number Fax Number

This Section to Be Completed by PARENT:

• As parent/guardian of the above named student, I request that the catheterization procedure as prescribed by the physician be administered at school.
• I agree to provide all the necessary supplies and equipment for the administration of the procedure.
• I understand it is my responsibility to notify the school if the orders change, and will provide updated physician orders.
• Unless otherwise specified, this order is good for the current school year and must be renewed each school year.
• My signature below indicates I am giving permission for the Elmbrook School staff to contact the physician for additional information, if needed.

______________________________ ( ) ________________ Date Telephone Number
Signature of Parent/Guardian Review Date

(for Health Office Use Only) ______________________________ School Nurse ________ Review Date