DUNCANVILLE INDEPENDENT SCHOOL DISTRICT

HEALTH SERVICES

MEDICAL ORDERS FOR SPECIALIZED HEALTH CARE PROCEDURES

Student_____ Date of Birth_____

Diagnosis_____ School Year _____

Procedure(s)

Catheterization: □ Clean □ Sterile Catheter Size _____Time(s_____

After catheterization, catheter is to be: □ Dispose of after each use

□ Cleaned and reused up to _____ times or _____ days Procedure for cleaning _____

□ Student is capable of self-catheterization and does not require assistance

Ostomy: □ Colostomy □ Ileostomy □ Urostomy □ Other _____

□ Ostomy Care/Frequency _____

Feeding: □ Tube, Size _____ □ Nasal □ Oral

□ Button, Type _____ Size _____ Location _____

□ Formula _____ Volume _____cc over _____ minutes at _____ (time(s)

□ Flush with water after feeding: Volume _____cc over _____ minutes

□ Gravity □ Pump, Type _____ □ May use gravity if no pump or pump malfunction

Tube/button will not be reinserted if dislodge at school, parent will be called immediately.

Suctioning: □ Nasal □ Oral Type: □ Bulb □ Catheter, Catheter size_____ Frequency _____

Tracheostomy: Trach type/size _____ Suction catheter size _____ Frequency _____

□ Trach may be reinserted by school nurse if dislodged (patient specific training/instruction required)

Person(s) authorized to provide service/procedure □ RN □ Health Care Assistant □ Trained School Staff □ Student

Other: _____

_____

Precautions: _____

_____

Special Instructions: _____

_____

Physician's Signature _____ Date: _____

Physician's Phone Number _____

To be completed by Parent/Guardian:

I request the School Nurse and/or trained staff member to administer the above procedure(s) according to the Physician's instructions. I agree to furnish all equipment and supplies necessary for administration of the service/procedure and to provide replacement and maintenance as needed. I understand the School Nurse may need to contact the Physician for clarification, concerns, and/or updates. **I will notify the School Nurse immediately of any change(s) to my child's status or Physician's orders.**

Parent's Signature _____ Date: _____

Parent's Phone Number(s) _____

□ Form received and reviewed on _____ (date) by _____ (School Nurse)

□ Equipment and Supplies received on _____ (date) by _____ (School Nurse)