Tustin Unified School District

Parent and Physician Consent for Individualized School Health Plan (ISHP)

Title of ISHP: Independent Student Clean Catheterization

Student: _____ DOB: _____ School: _____ Grade: _____

An Individualized School Health Plan (ISHP) provides specialized physical health care services for a student's health and safety at school. The specific ISHP (noted above) for this student has been developed collaboratively by the School Nurse in cooperation with the parents with information from the physician. **The ISHP will be implemented according to the attached plan/procedure, written parental consent, and written physician consent with any recommended modifications.**

Parent Consent for Individualized School Health Plan (ISHP)

- **California Education Code,** Section 49423.5 allows specialized physical health care services such as the attached ISHP, to be performed by designated school personnel under training and supervision provided by the School Nurse.
- **I, the undersigned,** who is the parent/guardian of the above-named student, request that specialized physical health care services according to the attached ISHP be provided for my child. I will assist as follows:
  - Provide the necessary and equipment.
  - Notify the School Nurse if there is a change in student health status or attending physician.
  - Notify the School Nurse immediately and provide new consents for any changes in doctor's orders.
- This request includes authorization for the School Nurse to communicate with the physician when necessary.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Physician Consent for Individualized School Health Plan (IHSP)

Type and size of catheter: _____ ☐ Student is independent

☐ Student independent but requires supervision ☐ Procedure to be done by trained staff

Catheterization time/s: _____ _____ _____

___☐__ I have reviewed and approved the ISHP for specialized physical health care services as written.

___☐__ I have reviewed and approved the ISHP for specialized physical health care services according to:

_____☐_____ my noted modifications _____☐_____ recommendations which I have attached

- I understand that specialized physical health care services will be performed by designated school personnel under training and supervision provided by the School Nurse.
- This consent is for a maximum of one year from this date: _____. If changes in procedure are indicated, I will provide written or fax orders.

_____
Physician Signature

_____
Physician Name Printed

Phone# _____ NPI# _____

Office stamp

For School Use Only:

_____ _____
School Nurse Signature Date

_____ _____
Principal Signature Date 5/13/19