Physician/Parent Request for Administration of Special Procedures

The school nurse will review the order for safe implementation. This specialized health care procedure will be administered by a Licensed Vocational Nurse, Registered Nurse or unlicensed trained person in accordance with the Texas Education Code Section 21.0003 (b) and upon receipt of this completed form along with any special equipment items.

Student: _____ DOB: _____ Age: _____ Grade: _____
Teacher: _____ Campus: _____
Diagnosis: _____
_____
_____

Procedure(s) required for student while in the school setting (check all that apply)

◯ Suctioning:
- ☐ Oral- as needed.
  - Additional Instructions: _____
- ☐ Tracheal – as needed: depth _____ cm
  - Use 3-5 gtts saline prior to suctioning
  - Additional Instructions: _____

◯ Oxygen:
- ☐ Give ____ LPM via NC/mask/trach-collar
- ☐ Continuous/PRN/ or at _____ for _____.
  (Time of day) (Condition)

◯ Gastrostomy tube feedings:

Supplement: _____ Amount: _____ml Give every _____ hrs
Given by: ◯ Pump ◯ Gravity ◯ Slow Push – over _____ min/hr
- ☐ Flush with _____ml water after feeding is complete
- ☐ Check residual prior to feeding – if residual is more than _____ml
  - ☐ Hold Feeding _____min, recheck residual
    - ☐ If more than _____ ml, hold feeding & inform doctor and parents
    - ☐ If less than _____ ml, feed student as ordered

Stoma/GT care: _____

◯ Urinary Catheterization:
- ☐ Catheterize every _____ hrs with _____ Fr catheter
- ☐ Student may self catheterize - _____ times a day or every _____ hrs

◯ VNS/Seizure Management - **Use seizure care plan**

We (I) undersigned, parent(s)/guardian(s) of _____request the above procedure be administered to our (my) child. We (I) authorize the School Nurse to contact our (my) child's physician(s) for information concerning my child when necessary.

Parent's Signature/Date: _____

Physician/Health Care Provider's Name/Date: _____

Physician/Health Care Provider's Signature: _____