Godley Independent School District

Special Medical Procedures Consent

The school nurse (RN) will review the order for the safe implementation. This specialized health care procedure will be administered on receipt of this completed form along with any special equipment items.

Student: _____ DOB: _____ Age: _____ Grade: _____

Teacher: _____ Campus: _____

Condition/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

- ○ **Diapering** – as needed

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

- **VNS/Seizure Management**
  - ☐ Swipe VNS at onset of seizures; then ever _____ min x _____ min or until seizures stop
  - ☐ If seizures last more than _____ min, give _____ _____ mg PR/Sublingal/PO
  - ☐ If rectal medication is expelled, do the following: _____
  - ☐ Call EMS/911 if seizure lasts more than _____ minutes
  - ☐ Call EMS/911 if _____

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

Physician/Health Care Provider's Signature: _____

PRN Medications

- Pain Medication:

Medication	Dose	Route	Time	MDs Signature

- Stoma/GT care:

- Diaper Rash Care:

- Other Reasons:

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