ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR CLEAN INTERMITTENT CATHETERIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: ____/____/____ Age: _____ Grade _____ Teacher _____

☐ Known drug allergies If drug allergies, please list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider.)

START DATE: _____ STOP DATE: _____

Size of Catheter	Frequency/Time(s)	Measure & Record Output?	Location for Procedure:
_____ Fr.		☐ Yes ☐ No	☐ Nurse's office bathroom ☐ Other: (Describe) ☐ Classroom bathroom

Storage: **Catheter will be discarded after each use, unless other instructions provided.**

_____

Self care is permitted and recommended for this student? Yes ☐ No ☐

- If" **no**", procedure is to be completed: ☐ By School Nurse ☐ With Assistance from School Nurse ☐ Supervised by School Nurse
- If" yes", do you recommend equipment, supplies be kept "on person" by the student? Yes ☐ No ☐
  I hereby affirm that this student has been instructed in the proper technique for self-care related to his/her clean intermittent catheterization procedure. _____ (Initials)

Potential Contradictions/Adverse Reactions _____

_____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider Date Phone Fax

PARENT AUTHORIZATION

I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment or supplies must be registered with the school nurse or his/her designee.

_____ _____ _____ _____
Signature of Parent Date Phone Cell

SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

_____ _____ _____ _____
Signature of Parent Date Phone Cell

revised 5/2014

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR GASTROSTOMY TUBE CARE

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____ School Year _____

Any known drug allergies/reactions? ☐ Yes ☐ No If yes, please list: _____

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ STOP DATE: _____

Type Formula	Reason for Taking	Route: Enteral	Amount per feeding: _____ ml.	Frequency/Time(s)

RESIDUAL and FLUSH:

Check residual before feeding? Yes ☐ No ☐ Notify prescriber if residual is greater than _____ ml? Yes ☐ No ☐	Flush before formula? Yes ☐ _____ ml. No ☐ Flush after formula? Yes ☐ _____ ml. No ☐	Flush before medication administered? Yes ☐ _____ ml. No ☐ Flush after medication is taken? Yes ☐ _____ ml. No ☐

STORAGE: Formula requires refrigeration after opening? Yes ☐ No ☐ Syringe/tubing stored in refrigeration? Yes ☐ No ☐

Self care is permitted and recommended for this student? *Yes ☐ No ☐

*If YES, I hereby affirm that this student has been instructed in the proper self-administration of the prescribed formula.

If' yes, do you recommend equipment, supplies and/or formula be kept "on person" by the student? *Yes ☐ No ☐

TYPE TUBE:

Mic-Key Button, Foley, Other:	Lumen size: _____ French	Length: _____ cm.	Balloon size: _____ ml.

Is student's stoma considered a mature stoma (At least 6-8 weeks post op)? Yes ☐ No ☐ *Date stoma considered mature: _____

- If the gastrostomy button or tube becomes dislodged after this date*, the school nurse, who has received specialized training approved by the Alabama Board of Nursing, will reinsert the gastrostomy tube/button or appropriate sized Foley catheter, tape it into place and contact the parent. The nurse will **NOT** inflate the tube/button or Foley balloon and will **NOT** provide an enteral feeding following reinsertion.
- If the gastrostomy button or tube becomes dislodged before this date*, the school nurse will immediately call the parent and prescriber. The parent or guardian will be responsible to pick up the student. The nurse will **NOT** attempt to reinsert the button. If bleeding from the stoma site, difficulty breathing or any change in status occurs 911 will be called immediately.

Treatment Order (Site Care, Dressing Change) : _____

(Attach additional sheet or use the back of this form if necessary)

_____
Printed Name of Licensed Healthcare Provider

Signature of Prescriber	Date	Phone	Fax

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to talk with the prescriber or pharmacist should a question come up about the procedure. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment and/or supplies must be registered with the school nurse, principal, or his/her designee. Formula must be in the original, unopened, sealed container and be properly labeled with the student's name.

Signature of Parent	Date	Phone	Cell

SELF-CARE AUTHORIZATION

(To be completed only if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

Signature of Parent	Date	Phone	Cell

ALABAMA STATE DEPARTMENT OF EDUCATION

revised 5/2014

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR TRACHEOSTOMY CARE

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

☐ Known drug allergies/reactions If drug allergies, list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: STOP DATE: _____

Tracheostomy Tube Info.

Brand: _____ * Size: _____ Length: _____

Check all that apply: ☐ Cuff ☐ Non-cuff ☐ Trach Tapes to hold in place

If yes, location of replacement tube: _____

Student will have Emergency Kit/"Go Bag" at school daily.

Humidifier Type: _____

Required care: _____

Tracheostomy Suctioning Orders:

Suction machine: Set to _____ mm Hg ☐ Will remain at school ☐ Will travel with student back & forth from school

Recommended depth for suctioning: _____ mm

Irrigate with normal saline prior to suctioning? ☐ No ☐ Yes ☐ PRN only Describe circumstance for prn saline w/suctioning: ___

_____.

Written instructions for cleaning machine are to be provided by parent and/or healthcare provider and are to be included in student's Individualized Healthcare Plan.

Suction Technique: ☐ Clean ☐ Sterile Catheter Size: _____ Replace catheter: ☐ Each time suctioned ☐ End of one day

***Is student authorized to complete self-suctioning care?** ☐ Yes ☐ No

If "yes", I hereby affirm that this student has been instructed in proper self-care for suctioning technique.

Unless student is authorized to perform self-care, all tracheostomy suctioning care will be provided by the licensed school nurse.

Tracheostomy Tube Replacement Order in Event of Accidental Decannulation:

I hereby authorize the Licensed School Nurse, who has received training and successfully completed a return skill demonstration, to replace this student's tracheostomy tube with * same size or one size smaller

Is student's breathing assisted via ventilator? Yes ☐ No

If "yes", please provide the following:

Ventilator Brand: _____

Ventilator Settings: _____

_____

Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____

Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I understand that additional parent/prescriber authorization forms will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedures. Procedure equipment and/or supplies must be registered with the licensed school nurse or his/her designee.

_____ _____ _____ _____

Signature of Parent **Date** **Phone** **Cell**

PARENTAL SELF-CARE AUTHORIZATION

(To be completed only if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the *above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

_____ _____ _____ _____

Signature of Parent **Date** **Phone** **Cell**