Calallen Independent School District Health Services
Physician's Order Form
Clean Intermittent Catheterization

Student Name_____ ID#:_____ DOB:_____

School:_____ Grade:_____

This patient has a condition that he/she is unable to void on his/her own. Clean Intermittent Catheterization is prescribed:

Cath via site _____

Catheter size _____

Catheterize every _____ hours or _____ times per day

Other instructions:

_____

_____

Precautions:

Contact the parent if the followings signs are noted. These symptoms may indicate a urinary tract infection:

- Cloudy urine
- Blood in the urine
- Foul smelling urine
- Fever of 100.4 or above.

It is also important to note that force should never be used to insert the catheter. If force is needed to insert the catheter, do not continue the procedure. The parent should be notified immediately.

Note:

Adjustment in the treatment or discontinuation of the treatment requires a written, signed physician's order. Order must be renewed each school year.

All equipment and supplies needed for the CIC will be provided by the parent.

Physician's Name _____ Phone_____

Physician's Signature_____ Date_____

Parent/Guardian Consent for Unlicensed Assistive Personnel to Perform CIC

I ☐ **do /** ☐ **do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a licensed nurse to administer medication or perform CIC to my child while in attendance at Calallen ISD or Calallen ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein.

Parent initials _____

Parent/Guardian Consent to Share Information and Picture

I ☐ **do /** ☐ **do not (**check one) authorize Calallen ISD to display a picture of my child (if applicable) and identify that this is a person with a health condition. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year.

Parent initials _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other CISD form requesting for school health care services.

Parent initials _____

Parent/Guardian Name _____

Phone #_____

Parent/Guardian Signature_____

Date _____