Pflugerville ISD Health Services

Updated 4/2024

Physician/Parent Request for Administration of Special Procedures

The school nurse (RN) will review the order for safe implementation. This specialized health care procedure will be administered by an RN, LVN, 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 NAME:	DOB:	STUDENT ID#:
CAMPUS:	SCHOOL YEAR:	
TEACHER:	GRADE:	
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______________ (Time of day) for________________ (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

◯ **Diapering:**

- ☐ Schedule: ____________________
- ☐ As needed: ____________________

◯ **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 Health Office Nurse to contact our (my) child's physician(s) for information concerning my child when necessary.

Parent's Signature: ____________________Date: ____________

Printed Name of Physician: ____________________

Physician's Signature: ____________________Date: ____________

Physician's Phone Number: ____________________ Fax: ____________