AISD Health Services

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 Registered Nurse, Licensed Vocational 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: _____

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

- **Thickener:**
  - □ Type: _____
  - □ Consistency: _____
  - □ Directions: _____

- **Diapering**
  - □ Scheduled: _____
  - □ As needed: _____

- **Urinary Catheterization:**
  - □ Catheterize every _____ hours with _____ Fr catheter
  - □ Student may self-catheterize - _____ times a day or every _____ hours

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O VNS/Seizure Management

- □ Swipe VNS at onset of seizures; then every _____ min x _____ min or until seizure stops
- ☐ If seizures last more than ___ min, give _____ mg PR/Sublingual/PO
- ☐ If rectal medication is expelled, do the following: _____
- ☐ Call EMS/911 if seizure lasts more than _____ minutes
- ☐ Call EMS/911 if _____

PRN Medications

O Pain Medication:

Medication	Dose	Route	Time	MDs Signature

O Stoma/GT Care:

O Diaper Rash Care:

O Other Reasons:

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

Parent's Signature/Date _____ _____

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

Physician/Health Care Provider's Signature: _____