



**PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER
AUTHORIZATION for Management of Urinary Catheterization in
Educational Settings and Sponsored Events**

School Year: _____
This authorization is valid for the current school year only

Student: _____ **DOB:** _____ **School:** _____

Physician's Written Authorization: Please check and initial all boxes that apply

Intermittent Urinary Catheterization

Technique: clean or sterile

Catheterization schedule:

Routine time(s) to be performed at school:

or per the following guidelines

Catheterize post void yes no

Record urine output yes no

Equipment:

Catheter: Size _____

Catheter should be replaced

daily or Every _____ days

Catheter should be cleaned with:

Soap and water

Other _____

Lubricant: yes no

If yes, specify type _____

Cleanser to be used prior to catheterization

Soap and water: yes no

Antiseptic Solution: yes no

If yes, specify type _____

Perineal wipes: yes no

If yes, specify type _____

Other _____

Can student independently self catheterize?

yes no

Does student require any staff assistance or supervision?

yes no

If yes, explain _____

Does the student have a known Latex Allergy:

yes no

The following medications would need to be given to this student in the event of a natural disaster where EMS and parent may be unavailable

List below or See Completed Medication Form

List any possible complications, signs or symptoms which would indicate this student may need medical attention or emergency care from a urinary standpoint:

List recommended interventions for the classroom staff

Medical Justification for providing this procedure during school hours is:

Physician Authorization for Specialized Physical Healthcare Service in School

- I understand that whenever possible, the healthcare procedure must be provided before or after school hours.
- I understand that the child may be transported a long distance to and from school and the only caretaker on the bus may be the bus driver. If this is inappropriate for this child I will indicate this.
- All authorization orders require annual renewal for each school year. I have reviewed the attached health care procedure guidelines and have made changes as necessary.
- The individual performing the procedure (not involving sterile technique) may or may not be a licensed registered nurse. The school administrator may designate another school employee to perform the service. If I believe the health care service must be performed by licensed personnel, I will indicate this.

Physician Signature _____ **Print Name** _____ **Date** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone _____ **FAX:** _____ **NPI#:** _____

Reviewed and Authorized by Parent/Guardian (signature) _____ **Date:** _____

Reviewed by School Nurse (signature) _____ **Date:** _____