



BAKER COUNTY DISTRICT SCHOOLS and
BAKER COUNTY HEALTH DEPARTMENT
SCHOOL HEALTH SERVICES



PROCEDURE PHYSICIAN ORDER FORM

(MUST be FILLED OUT COMPLETELY by PHYSICIAN/ HEALTHCARE PROVIDER)

Name: _____ D.O.B. _____ Grade: ____ Teacher: _____

Diagnosis: _____ School Yr. _____

Latex Allergy: ☐ Yes ☐ No Needs Assistance with Procedure: ☐ Yes ☐ No

PROCEDURES:

CATHETERIZATION: ☐ Clean ☐ Sterile Time of procedure _____

OSTOMY TYPE: ☐ Colostomy ☐ Ileostomy ☐ Urostomy ☐ Gastrostomy ☐ Jejunostomy

☐ Button ☐ PEG ☐ Other _____ ☐ Ostomy Care ☐ Frequency _____

FEEDING: Pump ☐ Yes ☐ No Type _____ ☐ Flow rate _____ cc/hr

Gravity ☐ Yes ☐ No Syringe ☐ Bag ☐ Check Residual ☐ Yes ☐ No Hold feeding for residual > _____ cc

Formula: _____ ☐ Volume to be given _____ cc over _____ min.

Volume of water to follow feeding _____ cc ☐ Time of feedings _____

Positions: During feeding _____

After feeding _____

☐ Tube Site care ☐ Frequency _____

SUCTIONING: ☐ Nasal ☐ Oral ☐ Tracheostomy ☐ Frequency _____

OXYGEN ADMINISTRATION: ☐ Type _____ ☐ Frequency _____

PERCUSSION AND POSTURAL DRAINAGE: ☐ Frequency _____

VENTILATOR- This requires consultation with the Baker Co. ESE Department- 259-7825.

OTHER _____

EQUIPMENT NEEDED (parent to supply): _____

PRECAUTIONS: _____

SPECIAL INSTRUCTIONS: _____

All nursing care is provided by or under the direction/ supervision of a licensed RN or LPN.

Authorization for Health Care Provider and School Nurse to Share Information:

I authorize my child's school nurse to assess my child in regards to his/her special health care needs and to discuss these needs with my child's physician as needed throughout the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature _____ Date _____

Doctor's Signature _____ Date _____
(Required)

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____ Date _____