



THOMAS COUNTY SCHOOLS

Dr. Lisa Williams, Superintendent

200 N. Pinetree Blvd., Thomasville, GA 31792

229-225-4380

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AUTHORIZATION FOR MANAGEMENT OF CLEAN INTERMITTENT CATHETERIZATION AT SCHOOL

Student Name: _____

School: _____ Grade: _____ Homeroom Teacher: _____

Date of Birth: _____

Allergies: _____

Physician Prescribing Catheterization: _____

Physician Telephone Number: _____

Parent/Guardian's Name #1: _____ Phone: _____

Parent/Guardian's Name #2: _____ Phone: _____

Physician's Order for Intermittent Catheterization **(to be completed by the Physician and returned to school)**

Diagnosis and reason for procedure to take place during school hours:

Type of catheterization in school: ☐ Clean Procedure ☐ Modified Sterile Procedure	Time/interval procedure is to be done:
Catheter Type: _____ Size: _____ ☐ Single Use ☐ Clean Catheter and reuse ☐ Duration of use _____ ☐ Cleaning technique for used catheter _____	Precautions and/or adverse reactions:
Lubricant: ☐ Self lubricating catheter ☐ Water-soluble lubricant	List any concerns for bus transportation:
Perineal Cleansing Product: ☐ Soap and water ☐ Rinse with water only ☐ Other: _____	Latex Allergy/Precautions: ☐ Yes ☐ No
Measure and record urinary output: ☐ Yes ☐ No	Other Instructions:

Health Care Provider Authorization For Management of Catheterization in School
My signature below provides the authorization for the above written orders. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.
Physician Signature: _____ Date: _____
Physician Name: _____
Address: _____
Telephone: _____

Parent Consent and Authorization for Management of Catheterization in School
I, the undersigned, the parent/guardian of the above named student, request my student be assisted with the above specialized health care procedure (clean intermittent catheterization). I agree to: 1. Provide all medications, supplies and equipment. 2. Notify the school if there is a change in the student's health status or attending physician 3. Notify the school immediately and provide a new consent for any changes in the doctor's orders. I authorize the School Nurse to communicate with the Authorized Health Care Provider when necessary in regards to this specific medication, procedure, and medical condition.
Parent/Guardian Signature _____ Date: _____
Parent/Guardian Name: _____