LEXINGTON COUNTY SCHOOL DISTRICT ONE

Lexington County School District One **Intermittent Catheterization** **Medical Orders** **School Year:**_____	For school use only: ❑ Routine ❑ PRN (As needed) Start Date:_____ D/C Date: _____

By signing this form, the parent/guardian and health care practitioner acknowledge that information provided on this form may be included in the student's Individual Healthcare Plan (IHP). Medications and/or treatments may be administered by an unlicensed, trained district employee.

Student Name	**DOB**	**Grade**	**School**
Diagnosis:	**ICD-10 Code:**		
Type/Location of ostomy (if present):		**Catheter Size:**	
Frequency of I/O catheterization:	**Measure and record output? Yes □ No □**		
Additional instructions for ostomy care: _____ _____ _____			

Instructions for when to contact Health Care Practitioner:

_____
_____
_____

Health Care Practitioner Name _____**Date**_____

Health Care Practitioner Signature _____

Phone_____ **Office Nurse's Name/other contact for questions** _____

I give permission for the treatments above to be administered as prescribed. I give permission for the school nurse to contact the health care practitioner named above and/or their designated employees to provide information about these orders and my child's health to the school nurse. I also give permission for this form to apply if I transfer my child to another school in Lexington County School District One during the current school year. I understand the school district and its employees and agents are not liable for an injury arising from administration of medication/ treatments authorized by an IHP. I agree to indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication/treatments authorized by an IHP. I agree to notify the school if my child's health condition changes.

Parent/Guardian Name_____**Date**_____

Parent/Guardian Signature_____

Phone (home)_____**(work)**_____**(cell)**_____