



PHYSICIAN/PARENT AUTHORIZATION FOR SPECIAL PROCEDURES

The School Nurse will review the order & ensure that it is completed & dated. Specialized health care will be provided when this form is completed in its entirety by both physician(s) & parents/guardians.

Student _____ ID# _____ DOB _____ Age _____

Grade _____ Teacher _____ School _____

TO BE COMPLETED BY PHYSICIAN:

Condition/Diagnosis: _____

Procedure (s) is required for student while in the school setting (check all that apply):

___ **Suctioning:** ___ Oral (as needed) ___ tracheal (as needed – depth _____ cm. Use 3-5 gtts saline prior to suctioning)

___ **Oxygen:** ___ Give ___ LPM via NC/mask/trach collar, continuous/PRN or at _____ for _____.
(Circle one) (Circle one) time of day Condition

___ **Tracheostomy Tube Reinsertion:** _____

___ **G-tube Feedings:** via NGT/G-tube/Jejunostomy/ Other: _____

___ Gravity Feed ___ Pump: set at _____ gtts / minute / hour ___ Slow push over _____ min/hr

___ Give _____ cc of _____ at _____ AM/PM _____ AM/PM _____ AM/PM

___ Flush / irrigate with _____ cc of water after each feeding

___ Check for Residual prior to each feeding. If there is _____ cc residual, hold feeding for _____ minutes then re-check residual. If more than _____ cc, hold feeding & inform MD & parents/guardian if less than _____ cc, feed student as ordered

___ Tube Reinsertion _____

___ Other _____

___ Other Feeding recommendations: _____

Feeding Instructions:

Positioning: _____ Amount of food per bite _____

Equipment: _____ Keep student upright for _____ minutes after meal

Diet / Food Preparation:

Food Consistency: Pureed ___ Ground ___ Chopped ___ Mashed ___ Bite Size ___

Liquid Consistency: No liquids ___ Thin liquids ___ Thickened liquids ___

Other: _____

__ **Catheterization: Catheterize / Self-Cath** (Circle one that applies) at _____ AM/PM _____ AM/PM

__ **Diaper Change:** at _____ AM/PM _____ AM/PM _____ PRN

__ **VNS/Seizure Management** __ Swipe VNS at onset of seizures: then every _____ min. x _____ min. or until seizures stop __ If seizures last more than _____ min. give _____ mg. PR/Sublingual/PO __ If rectal medication is expelled, do the following _____

__ Call EMS/911 if seizures lasts more than _____ minutes.

__ Call EMS/911 if _____

__ **Blood Pressure Monitoring:** Frequency: _____ Duration: _____

If BP is greater than _____, inform MD and parent/guardian

If BP is less than _____, inform MD and parent/guardian

__ Other:(Describe): _____

Physician's Name _____ Date _____

Physician's Signature _____

Address _____

Phone # _____ Fax # _____

TO BE COMPLETED BY PARENT/GUARDIAN:

We (I), the undersigned, parent(s)/guardian(s) of _____ request the
Student's Name

procedure be administered to our (my) child. We (I) authorize the School Nurse to contact our (my) child's

physician(s) for further information concerning my child when necessary. We will notify the school immediately if

the health status of our child changes, we change physicians or there is a change or cancellation of the procedure.

Parent/Guardian Signature _____ Date _____

Phone# (Home) _____ Work # _____ Cell # _____