# El Paso County School Health Services
# Specialized Healthcare Procedures Practitioner's Written Order

Student's Name: _____ DOB: _____

School: _____ Year: 20 _____ - 20 _____

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the above school year or until there is a change or cancellation of the procedure(s).

Medical Diagnosis: _____

Allergies: _____

**Incontinence Care**

Diaper q _____ hrs or PRN

| Medication Name | Dosage | Time | Route |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Other: _____

**Wound Care**

Dressing changes: q _____hrs

Location: _____

| Medication/s: Name | Dose | Time | Route |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Wound care instructions: _____

_____

_____

**Blood Pressure Monitoring**

BP q_____hrs x day x _____wks

- ☐ BP right arm
- ☐ BP Left arm
- ☐ BP both arms

If BP is greater than_____ or less than _____Notify Practitioner /Parent

**Intravenous Lines ( Monitoring Only)**

Catheter Type:

- ☐ Heplock
- ☐ PICC
- ☐ Central Line/Type _____
- ☐ Broviac
- ☐ Porta Cath/Type_____
- ☐ Peripheral
- ☐ Other _____

Restrictions : _____

_____

_____

**Other Procedures/ Treatments/ Medical Orders**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.**

**Practitioner's Name:** _____

_____ _____ _____

**Practitioner's Signature** **Office Phone Number** **Date**

# El Paso County School Health Services
# Specialized Healthcare Procedures Practitioner's Written Order

**To be completed by Parent/Guardian/Debe ser completado por Padre/Tutor**

**Authorization and Consent for Services**
I request and authorize the school nurse and trained school personnel to perform or monitor the above ordered procedure as prescribed by my child's physician. I will provide the school with the necessary supplies/equipment to perform this service for my child. I will also provide written notification from the physician if the treatment changes or is discontinued. This authorization will be in effect for the above stated school year.

_____ _____
**Parent/Guardian Signature** **Date**

**Autorización y Consentimiento Para Servicios**
Solicito y autorizo a la enfermera y al personal escolar capacitado a realizar o supervisar el procedimiento prescrito por el médico de mi hijo/a, mencionado anteriormente. Proporcionare a la escuela con los suministros/equipos necesarias para llevar a cabo este servicio para mi hijo. También proporcionaré la notificación por escrito del médico si el tratamiento cambia o se discontinúa. Esta autorización estará en efecto para el susodicho año escolar indicado.

_____ _____
**Firma del Padre/Tutor** **Fecha**

**Authorization to Release and Obtain Medical Information**
I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

_____ _____
**Parent/Guardian Signature** **Date**

**Autorización Para obtener y Divulgar Información Médica**
Autorizo la divulgación de información sobre los procedimientos y servicios especializados de salud relacionados con la condición de mi hijo entre el médico tratante de mi hijo/a, la enfermera de la escuela y personal de la escuela que necesita tener esta información para mantener la seguridad, la salud y el cuidado de mi hijo/a. Esta autorización estará en efecto para el susodicho año escolar indicado.

_____ _____
**Firma del Padre/Tutor** **Fecha**