Clint ISD School Health Services
Urinary Specialized Healthcare Procedures Practitioner's Written Order

Student's Name: _____ DOB: _____

School: _____ Year: 20_____-20_____

Medical Diagnosis: _____

Allergies: _____

Fill out the appropriate box and complete the related information

Catheterization

□ Intermittent catheterization by school staff

□ Intermittent catheterization by student (self-cath)

Student will require assistance or monitoring with self-cath □ YES □ NO

Catheter Fr size: _____

Frequency:

Every _____ hours or at the following specific time(s): _____

Call physician for a urinary output of less than _____ml in a 7-8 hour school day.

Urostomy

Stoma Care: Apply the following medication

Medication	Dosage	Time	Route
_____	_____	_____	_____
_____	_____	_____	_____

Appliance size, barrier, paste, etc. _____

Other: _____

_____

Additional Information: _____

_____

I, the undersigned, as the physician for the above-named student, approve the 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).

_____ _____
Physician Signature Date

_____ _____
Physician's Printed Name Office Number

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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 de 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 de Padre/Tutor Fecha