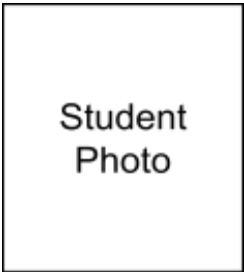




Fairbanks North Star Borough School District
Urinary Catheter Care Plan



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

MEDICAL PROVIDER AUTHORIZATION

EQUIPMENT *(provided by parent/guardian to Health Office)*

- Straight Cath Kits Fr: _____
 Sterile gloves
 Iodine swabs
 Lubricant
 Wipes
 Non-sterile gloves
 Chux
 Diapers
 Other: _____

URINARY CATHETER CARE

Sterile procedure Complete straight cath every _____ hours or specific times as listed: _____, _____, _____, _____ Monitor and record urinary output Other (specify): _____ _____	Clean procedure Do not monitor and record urinary output
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OTHER ORDERS

MEDICAL PROVIDER NAME/TITLE	PHONE
MEDICAL PROVIDER SIGNATURE	DATE

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL



Fairbanks North Star Borough School District
Urinary Catheter Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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PARENT/GUARDIAN AGREEMENT AND AUTHORIZATION

I request that urinary care, as ordered by my child's licensed healthcare practitioner, be provided during school hours. I will supply all necessary equipment and will notify the school in writing of any changes to the care plan.

Employees and agents of the Fairbanks North Star Borough School District ("FNSBSD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify FNSBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the healthcare practitioner listed on this plan and FNSBSD as part of the provision of my child's care. I agree for the Health Office to share health information with FNSBSD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining urinary care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the FNSBSD school year calendar.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL.

PARENT/GUARDIAN NAME	RELATIONSHIP TO STUDENT	PHONE NUMBER
PARENT/GUARDIAN SIGNATURE		DATE

NURSE PLAN REVIEW AND STAFF TRAINING

I have reviewed the Urinary Catheter Care Plan for accuracy and ensure that all required fields and signatures are completed before prior to implementing care for the a student. I approve of the agreement arranged between the healthcare practitioner, parent/guardian, Health Office, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety, dignity and well-being of the student in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE

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