

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order: Clean Intermittent Catheterization in School Setting	
Student's Name _____	DOB _____
Student's Address _____	
Student's Phone # _____	Student's I.D _____
Parent/Guardian Name _____	
Phone: Work _____	Cell _____
Parent/Guardian Name _____	
Phone: Work _____	Cell _____
Preferred Hospital _____	
School _____	Teacher/Grade/Homeroom _____
Student's Diagnosis: _____	
Please have the student's Health Care Provider complete the following information: <ol style="list-style-type: none"> 1. Catheterize student with catheter type: _____ size # at _____ am/pm daily while in school using proper clean technique. 2. Route (Please circle one): Urethral Suprapubic 3. Observe for signs and symptoms of urinary tract infection including: dark or cloudy urine, foul/strong smelling urine, blood, discharge, abdominal/flank pain, vomiting. 4. Report signs and symptoms to parent/guardian. 5. If unable to successfully catheterize student, call parent/guardian. 6. Document care daily on procedure flow sheet. 7. Maximum amount of urine to be obtained with each catheterization: 8. Other: 9. Duration of order: School Year _____ 	
Health Care Provider _____	Phone # _____ FAX # _____
Address _____	
Health Care Provider Signature _____	
Date _____	
Return Authorized Order by Fax to School Nurse _____	
School Nurse Fax # _____	
I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.	
Parent /Guardian Signature _____	Date _____
School Health Nurse Signature _____	Date _____

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