

IHP for Student Requiring Catheterization

Name _____ Date of Birth _____
Parent/Guardian _____
Phone (h) _____ (w) _____ (c) _____
Physician _____ Phone _____
Fax _____

Medical History/ Diagnoses:

Medications:

Activity Limitations or Restrictions:

Procedure:

Urinary Catheterization: ☐ Urethral ☐ Suprapubic

Frequency: _____

Times Catheterization is needed:

Student self cath: ☐ YES, independently ☐ NO ☐ With Adult Assistance

Contact parents or health care provider if the following are observed:

Additional Health Care Provider or Parent Comments:

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Physician Consent for Student with Multiple Medical Needs

I have reviewed and approved this management plan and have included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.

Other Comments:

Physician/Health Care Provider Signature

Date

Parent Consent for Student with Multiple Medical Needs

I, as parent/guardian, concur with the above management plan, and will provide the necessary supplies, medications and equipment, will notify the school nurse if there is any change in our child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

Parent/Guardian Signature

Date