PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of Clean Intermittent Catheterization (CIC) in Educational Settings and Sponsored Events

Student:	**DOB:**	**Date:**
District/Site:	**Teacher/Rm:**	**Grade:**

1. **Latex Allergy:**
   - ☐ YES
   - ☐ No
2. **Catheterization frequency:** (may include Extended Learning hours)
   - ☐ Every _____ hours
   - ☐ As needed (PRN)
3. **Catheterize via:** ☐ Urethra ☐ Stoma _____
4. **Single-use Catheter Type**: _____
   - ☐ Straight ☐ Coudé ☐ Olive ☐ Other _____
   - Size _____ Fr
   - *Research and evidence-based practice supports single-use catheters to minimize CAUTI in educational settings.
5. **Lubricant**
   - ☐ Water soluble lubricant/gel
   - ☐ Hydrophilic - use water ☐ pre-lubricated
6. **Genitalia cleaning product**:
   - ☐ Unscented wet wipes
   - ☐ Cotton balls and soap _____
   - ☐ Other: _____
7. **Measure urinary output**
   - ☐ Yes
   - ☐ No
8. **Amount of fluid intake during school day**:
   - ☐ Unlimited – no restrictions
   - ☐ Limited to _____ cc
   - ☐ Minimum of _____ cc
9. **Student may:**
   - ☐ Perform self-catheterization
   - ☐ Assist with self-catheterization to the extent possible
   - ☐ May not assist with self-catheterization
10. **Medication installation in the bladder** (modified aseptic technique). **Medication form must be attached.**
    - ☐ Yes
    - ☐ No
11. **Other:**

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date**_____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

Authorization for Trained Unlicensed Person

CIC may be performed by a trained unlicensed person. ☐ **Yes** ☐ **No**

Medication instillation in the bladder may be performed by a trained unlicensed person. ☐ **Yes** ☐ **No**

Health-Care Provider Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of Clean Intermittent Catheterization (CIC) in Educational Settings and Sponsored Events

Student:	**DOB:**	**Date:**

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____

☐ **Credentialed school nurse has informed principal about health-care services provided for this student.**