

Physician/ Parent Request for Administration of Special Procedures

The school nurse (RN) will review the order for safe implementation. These specialized health care procedures will be administered by a RN, LVN, or unlicensed, trained personnel, in accordance with TEC 21.0003 (b), and upon receipt of this completed form.

Student Name: _____ DOB: _____ Student ID#: _____

Campus: _____ Teacher/ Grade: _____

Condition/ Diagnosis: _____

Procedure(s) required for student while in the school setting (Select All That Apply):

☐ **Suctioning:** Select All That Apply

☐ Oral: As Needed

- Additional Instructions: _____

☐ Tracheal: As Needed

- Depth: _____ cm
- Normal Saline Instilled Prior to Suctioning: ☐ YES _____ gtts ☐ NO
- Additional Instructions: _____

☐ **Oxygen:** Select All That Apply

☐ Continuous oxygen at _____ LPM via ☐ Nasal Cannula ☐ Mask ☐ Trach Collar

☐ PRN oxygen at _____ LPM via ☐ Nasal Cannula ☐ Mask ☐ Trach Collar

- If SpO2 is below < _____ % on room air

☐ **Gastrostomy Tube Feedings:** Select All That Apply

- Formula: _____ Method: ☐ Pump ☐ Gravity ☐ Slow Push over _____ min/ hr

- Amount/ Frequency: _____ mL every _____ hrs OR at _____ AM | PM

☐ Flush with _____ mL water ☐ before feeding and/ or ☐ _____ mL water after feeding

☐ Check residual prior to feeding:

- ☐ If residual > _____ mL, hold feeding and inform parents and provider

- ☐ If residual < _____ mL, feed student, as ordered

- Stoma/ Tube Care/ Additional Instructions: _____

☐ **Urinary Catheterization:** Catheterize _____ times/ day OR every _____ hrs with _____ Fr catheter

- Student may self- catheterize: ☐ YES ☐ NO

☐ **Diapering** ☐ PRN ☐ Scheduled Special Instructions: _____

I hereby request the School Nurse or trained staff member to administer the above procedure(s). I agree to furnish all equipment, tubing, and other supplies necessary for the administration of the service/ procedure listed above. I authorize the School Nurse to contact my child's health care provider for information concerning my child when necessary.

Parent/ Guardian Signature: _____ Date: _____

Physician's Phone #: _____ Physician's Fax #: _____

Physician's Printed Name: _____ Physician's Signature: _____