Physician / Parent Authorization for Administration of Special Procedures

The School Nurse will review the order & ensure that it is completed & dated. Specialized health care will be provided when this form is completed in its entirety by both physician(s) & parent/guardian.

Student_____ID#_____DOB_____Age____Grade_____
Teacher_____ Campus_____

Condition/Diagnosis:_____

Procedure(s) is (are) required for student while in the school setting (check all that applies):

❑ **Suctioning:** ❑ Oral (as needed) ❑ tracheal (as needed-depth _____cm. Use 3-5gtts saline prior to suctioning)

❑ **Oxygen** Give _____LPM via NC/ mask/ TC, continuous/ PRN or at _____for _____condition.
(Circle one) (Circle one) (time of day)

❑ **Nebulizer Treatments**: Give via mask/hand-held/trach collar/ _____(identify mode)
- ❑ Give _____every _____hrs. X _____days/ ongoing.
- ❑ Give PRN for oxygen saturations < _____q hrs. X _____ times

❑ **Tracheostomy Tube Reinsertion**: _____

❑ **Tube Feedings**: via NGT/G-tube/Jejunostomy/Other: _____
- ❑ Gravity Feed _ Pump: set at _____gtts/minute/hour _Slow push _____over min/hr
- ❑ Give _cc of _____at _____AM/PM_____AM/PM _____AM/PM
- ❑ Flush / irrigate with _____cc of water after each feeding
- ❑ Check for Residual prior to each feeding. If there is _____cc residual, hold feeding for _____ minutes then re-check residual.
  If more than _____cc, hold feeding & inform MD & parents/guardian
  If less than _____cc, feed student as ordered
- ❑ Tube Reinsertion:_____
- ❑ Other:_____

❑**Catheterization:** Catheterize / Self-Cath (Circle one that applies) at _____AM/PM _____AM.PM

❑ **Diaper Change**: at _____AM/PM _____AM/PM _____PRN

❑ **VNS/Seizure Management:**
- ❑ Swipe VNS at onset of seizures: then every _____ min. x _____min. or until seizures stop.
- ❑ If seizures last more than _____ min. give _____ _____mg. PR/Sublingual/PO
- ❑ If rectal medication is expelled, do the following _____
- ❑ Call EMS/911 if seizures lasts more than _____ minutes.
- ❑ Call EMS/911 if _____

❑ **Blood Pressure Monitoring:** Frequency: _____Duration: _____
If BP is *greater than* _____, inform MD and Parent/guardian
If BP is *less than* _____, inform MD and parent/guardian.

❑ **Other: (Describe):** _____

_____

We (I), the undersigned, parent(s) / guardian(s) of _____ request the above procedure(s) be administered to our (my) child when necessary. We will notify the school immediately if the health status of our child changes, we change physicians or there is a change or cancellation of the procedure.

_____ _____
Parent/Guardian Name/ Signature Date Phone #

_____ _____
Physician's Name /Signature Date Phone #

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