Valid for school year ___________

Photo (optional)

Dickinson Independent School District
School Health Services
Physician Order/Parent Request for Administration of Special Procedure

The school/campus nurse will review the order for safe implementation. The procedure(s) will be administered upon receipt of this completed and physician/parent signed form *along with any special equipment and/or items required.*

Student___________________________________**Student ID**__________**Date of Birth**______________

Grade_______**Teacher(s)**__________________________**Campus**________________**Date**___________

Condition/Diagnosis: ☐ Cerebral Palsy ☐ Spina Bifida ☐ Other____________________________________

Procedure(s) required for student while in the school setting (check all that apply pages 1-3):

Diapering:____
Diaper rash care: ____
Bathroom Assistance for students requiring assistance on a routine basis __________________________

Urinary Catheterization:

- Catheterize every_________hrs **or** at_____________time(s) with________Fr catheter
- Student may self catheterize at______________time(s) a day **or** every_________hrs
- PRN Catheterize when the following signs/symptoms are noted: ______________________________

Gastrostomy/Mic-Key/PEG Tube Feedings**:**

- Is student NPO (nothing by mouth)? **YES** **or** **NO** (If NO, see attached form needed from Physician)
  - The attached form is also required for all texture modified oral feedings when a student has g-tube and/or trach
  - Food Substitution form is also required if the student's oral feeding meal will be prepared by the school cafeteria
- Type of diet required if permitted to have oral feedings with g-tube and/or trach: _______________________
- G-tube formula/supplement_______________________Amount (volume) per feeding ____________

  Give every_________hours **or** at specific time(s) _____________________
  - Does formula/supplement require mixing of powder or liquid? If YES, write the recipe below:

    ____
  - Feeding is given via **GRAVITY or PUMP** set at__________cc/hr

- Check residual prior to feeding - IF residual is more than_______ml
  Hold feeding_______minutes, recheck residual
  If residual more than______ml, hold feeding & inform doctor and parents
  If residual is less than_______ml, feed student as ordered

- When feeding complete, flush g-tube with________ ml water

If Gastrostomy tube is pulled/falls out: *cover stoma with dry gauze and call the parent/guardian ASAP*

*** Dickinson ISD nurses and/or personnel DO NOT reinsert Gastrostomy/Mic-Key buttons/tubes***

Stoma/G-tube Care:

- Daily at_____________(time of day) Care as described below:
  ____
- As needed when the following signs/symptoms are noted, using the care as described below:
  ____
  ____
- Any signs of redness, inflammation, or leakage around G-tube will be assessed by campus nurse and discussed with parent/guardian.

Does the student have a VP Shunt? **NO** **Yes** (IF Yes, then MISD Shunt Care IHP form needed)

Suctioning:

- Chest PT Vest ____
- Oral suctioning - as needed using a___________________________suction catheter
- Tracheal suctioning - as needed, depth____________cm
- Use 3-5 gtts saline prior to suctioning
- If Trach Care is needed, the MISD Trach IHP form will need to be completed

Oxygen:

- Administer_________LPM via NC/mask/trach-collar continuously
- Administer_________LPM via NC/mask/trach-collar PRN for ____________________________
- Administer_________LPM via NC/mask/trach-collar__________(time of day)
- Administer_________LPM via NC/mask/trach-collar for O2 Sats <_______%
- Maintain O2 Sats between_______________% using O2 via_____________@_________LPM

- Additional Equipment/supplies needed (to be provided by parent):
  ____
  ____
- Precautions needed if student is to ride school bus: (BUS #_______)
  ____
- Other specific care (describe in detail)
  ____
  ____

Student________________________________**Student ID**______________**Campus** ______________

Circumstances in which the physician should be contacted: ____

____

It is impossible to schedule the above-mentioned medication/procedures at a time other than school hours. I request that this medication/procedure be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication/procedure. I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result.
I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education Right s and Privacy Act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

I request that the procedure(s) above be administered to my child according to the signed protocol from my physician. I hereby give permission for the school/campus nurse to consult with the prescribing physician or specialist regarding the order above.

Printed Name of Parent/Legal Guardian ___________________________________

Parent/Legal Guardian Signature____Date____________________

Contact number(s)____Work #___________________________

Based on the evaluation as a licensed physician, the above named student **requires the above health care service in order to attend school.** I certify that the student is under my continuing care. This care includes monitoring the student's continuing need for any needed modifications of the services prescribed above.

Printed Physician's Name (print)___________________________________Date ______________________________

Physician's Signature_______________________Phone____________________Fax__________________________

Nurse line/direct phone number ________________________________

The following is a current list of my child's doctors and/or prescribing specialists for the procedures requested on this document. The Parent/Guardian will update this information as needed throughout the school year.

Primary Care Doctor:____Phone# _______________________

Genitourinary (GU) Doctor:____Phone# _______________________

Pulmonologist:____Phone#________________________

Gastroenterologist (GI) Doctor:_______________________________________Phone#________________________

Other:____Phone#________________________

DME Company____Phone # _______________________