LONG COUNTY SCHOOL HEALTH SERVICES

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR CLEAN INTERMITTENT CATHETERIZATION

STUDENT INFORMATION

Student's Name _____ **School:** _____ **School Year:** _____

Date of Birth: ____/____/____ **Age:** _____ **Grade** _____ **Teacher** _____

☐ **Known drug allergies** **If drug allergies, please list:** _____ **Weight:** _____ **pounds**

PRESCRIBER AUTHORIZATION
(To be completed by licensed healthcare provider.**)**

START DATE: _____ **STOP DATE:** _____ _____

Size of Catheter _____ **Fr.**	**Frequency/Time(s)**	**Measure & Record Output?** ☐ **Yes** ☐ **No**	**Location for Procedure:** ☐ **Nurse's office bathroom** ☐ **Other: (Describe)** ☐ **Classroom bathroom**

Storage: Catheter will be discarded after each use, unless other instructions provided.
_____

Self care is permitted and recommended for this student? **Yes** ☐ **No** ☐

- If" **no"**, procedure is to be completed: ☐ By School Nurse ☐ With Assistance from School Nurse ☐ Supervised by School Nurse
- If" **yes"**, do you recommend equipment, supplies be kept "on person" by the student? Yes ☐ No ☐
  I hereby affirm that this student has been instructed in the proper technique for self-care related to his/her clean intermittent catheterization procedure. _____
  (Initials)

Potential Contradictions/Adverse Reactions _____

_____

_____
Printed Name of Licensed Healthcare Provider

_____ _____ _____ _____
Signature of Licensed Healthcare Provider **Date** **Phone** **Fax**

PARENT AUTHORIZATION
I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment or supplies must be registered with the school nurse or his/her designee.

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

SELF-CARE AUTHORIZATION
(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

Updated 6/17 kg