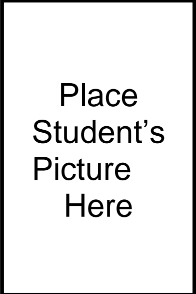
School: ______________________________ School Year: ______________

PHYSICIAN AND PARENT/GUARDIAN AUTHORIZATION FOR CATHETERIZATION PROCEDURE



Student's Name:____________________________________**DOB:** _____________

Allergies:____

School:_________________________Teacher:_________________Grade:___________

Parent/Guardian(s) Name(s): ____

Parent/Guardian #1: Home:_______________Work:______________ Cell: ______________

Parent/Guardian #2: Home:_______________Work:______________Cell:_______________

Address/Zip Code: ____

Physician:_______________________Phone #:_____________Hospital of Choice: _________________

Physician Order and Parent/Guardian Authorization for CATHETERIZATION

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Heath Division, 650 Newtown Pike, Lexington, KY 40508

Student Name:___________________________**Gender:**__________**Date of Birth:** ______________

Allergies:__________________________**Medications**:_________________________________

Student's Medical Diagnosis: ____

Order for Catheterization Procedure:

☐ **Mitrofanoff**

☐ **Intermittent Catheterization by School Nurse or trained school staff**

☐ **Intermittent Self-Cath by Student**

Student requires Supervision/Monitoring: ☐ **Yes** ☐ **No**

Frequency of Catheterization during school day: ___________________________

Output needs to be measured each time: ☐ **Yes** ☐ **No** **Size of Catheter:** ________________

Comments/Instructions:

X__________________________________ ______________________________

(Physician's Signature) Date

__________________________________ ______________________________

(Physician's Name - Printed) Telephone Number

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PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of_________________________________, hereby **request the School Nurse or trained staff to administer** the above procedure(s) according to the Physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

☐ I give consent for my **student to self-administer** the above procedure, according to Physician's instructions. I agree to notify the School Nurse if monitoring is necessary. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

*****I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders.**

Parent/Guardian Signature:______________________________ **Date:**_____/ _____/ _____

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Reviewed by:____________________________________***RN*** ***Date:*** _________________