SCHOOL YEAR _________

Lexington-Fayette County Health Department

School Health
650 Newtown Pike
Lexington, KY 40508-1197
(859) 288-2314
(859) 288-2313 Fax

PARENT PACKET - CATHETERIZATION

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are the forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse at your school:

- **Student Health Information Sheet**
- **Physician & Parent/Guardian Authorization for Catheterization Procedure**

We are looking forward to a great year with your student!

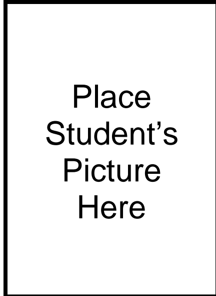
Please call the School Health Services program at 288-2314 if you have any questions.

STUDENT HEALTH INFORMATION SHEET

School Year: _________

MEDICAL CONDITION: _________________________

(This form will be made available to teachers and appropriate school staff.)



Student's Name: ___________________________________ **DOB:**____ / ____ / ____

Allergies: ____

School: _________________________ Teacher: _________________ Grade: _____

Bus Rider: ☐ Yes ☐ No Bus #: AM _____ PM _____ Non-Transported ☐

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

Address/Zip Code: ____

Call Parent/Guardian 1: – Home: ________________ Work: ________________ Cell: ________________

Call Parent/Guardian 2: – Home: ________________ Work: ________________ Cell: ________________

Alternate contact person in case of emergency:

Name: _____________________________ Relationship: _______________ Phone: ______________

PHYSICIAN'S NAME: ____ PHONE: _____________

HOSPITAL OF CHOICE: ____

HISTORY OF MEDICAL CONDITION - Include date of onset and most recent concerns: ________________

____

____

* MEDICATIONS & TREATMENTS AT SCHOOL: ____

____

____

ADDITIONAL COMMENTS: ____

____

____

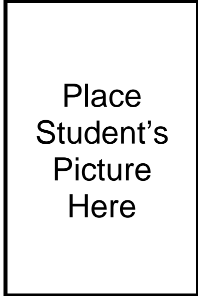
DATE COMPLETED: ____ / ____ / ____ COMPLETED BY: ___________________________________

* *Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

REVIEWED BY: ___________________________________, RN DATE: _____ / _____ / _____

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 FOR INTERMITTENT 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'S NAME: __________________________________ **DATE OF BIRTH:** ______________

ALLERGIES: ____

STUDENT'S MEDICAL DIAGNOSIS: ____

FREQUENCY OF CATHETERIZATION DURING SCHOOL DAY: ______________________________

ORDER FOR CATHETERIZATION PROCEDURE:

☐ **Intermittent Catheterization by School Nurse**
☐ **Intermittent Catheterization by Student**

COMMENTS: ____

X ____ ________________________
(Physician's Signature) Date

____ ________________________
(Physician's Name - Printed) Telephone Number

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of _________________________________, hereby **request the School Nurse 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 agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders.

☐ 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:** _____ / _____ / _____

Reviewed by: _________________________________***RN*** ***Date:*** __________________