Lexington-Fayette County Health Department

SCHOOL HEALTH DIVISION
650 Newtown Pike
Lexington, Kentucky 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.)

Place Student's Picture Here

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: ____

Place Student's Picture Here

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

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: __________________