AUSTIN Independent School District | Health Services and Nursing

Physician / Parent Authorization for Administration of Special Procedures

The School Nurse will review the order & ensure that it is completed & dated. Specialized health care will be provided when this form is completed in its entirety by both physician(s) & parents/guardians.

Student _____ID#_____Date of Birth _____Age _____Grade_____

Teacher_____Campus _____

Condition/Diagnosis: _____

The procedure(s) is required for student while in the school setting (check all that apply):

__**Suctioning**:___Oral (as needed)___tracheal (as needed – depth_____cm. Use 3-5 gtts saline prior to suctioning)

__**Oxygen:**___Give____LPM via NC/mask/trach collar, continuous/PRN or at_____for_____.
(Circle one) (Circle one) time of day Condition

__**Nebulizer Treatments:** Give via mask/hand-held/trach collar/_____(identify mode)
___Give_____q____hrs. x_____days/ongoing
___Give PRN for oxygen saturations <_____q_____hrs. x_____times

__**Tracheostomy Tube Reinsertion:** _____
(***A Manual Resuscitator or Ambu Bag must be with a student who has a tracheostomy tube at all times***)

__**G-tube Feedings:** via NGT/G-tube/Jejunostomy/ Other: _____
___Gravity Feed___Pump: set at_____gtts / minute / hour____Slow push_____over min/hr
___Give_____cc of_____at_____AM/PM_____AM/PM_____AM/PM
___Flush / irrigate with_____cc of water after each feeding
___Check for Residual prior to each feeding. If there is_____cc residual, hold feeding for_____minutes then re-check residual. If more than ___cc, hold feeding & inform MD & parents/guardian if less than __cc, feed student as ordered
___Tube Reinsertion: _____
___Other: _____

__**Catheterization: Catheterize / Self-Cath** (Circle one that applies) at_____AM/PM_____AM/PM

__**Diaper Change:** at_____AM/PM _____AM/PM _____PRN

__**VNS/Seizure Management**
___Swipe VNS at onset of seizures: then every_____min. x_____min. or until seizures stop
___If seizures last more than_____min. give _____ ____mg. PR/Sublingual/PO

___If rectal medication is expelled, do the following _____
___Call EMS/911 if seizures lasts more than_____minutes.
___Call EMS/911 if _____

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_____

_ **Blood Pressure Monitoring:** Frequency: _____ Duration: _____
If BP is greater than _____, inform MD and parent/guardian
If BP is less than _____, inform MD and parent/guardian

__ Other: (Describe): _____
_____
_____

Infusion Therapy: ____ Heplock _____PICC _____Central Line & Type _____ Other: _____

Pump Setting: _____ gtts / minute / hour (if applicable) _____

Fluid to be infused & volume _____

Infusion Times: _____hours / day Flushing Solution/Amount: _____ cc(prior) &/or(after) infusion
(Circle "prior," "and/or" "after)

Other Fluids to be infused: _____
(Name, Dosage, Frequency, Time, Route (Piggyback, etc.) and DC Date)

We (I), the undersigned, parent(s)/guardian(s) of_____request the above
Student's Name
procedure be administered to our(my) child. We (I) authorize the School Nurse to contact our (my) child's physician(s) for further information concerning my child when necessary. We will notify the school immediately if the health status of our child changes, we change physicians or there is a change or cancellation of the procedure.

_____ _____
Parent/Guardian Signature Date

_____
Address

_____ _____ _____
Phone (Home) Work # Cell#

_____ _____ _____
Physician Name Clinic Name Clinic Phone Number

_____ _____
Physician Signature Date