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/ ☐ sk/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