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_________________.

(Circlenuous/ 0re35

_ **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 (m) bed(F)1..7(u)-25 (hd0Tc 0Tmn/)-4(3 (&-ni114Td2)-4)/da5.h40T7(A8.6/( ) Ts