Washington County Public Schools/ Meritus Health

HEALTH PROVIDER ORDER INTERMITTENT URINARY CATHETERIZATION

Student's Name:	Date of Birth:
School:	Grade:
☐ This order is valid for the current school year _____ (including summer) ☐ Start date: _____ End date: _____	
HEALTH CARE PROVIDER TO COMPLETE	
Diagnosis or Condition for Treatment:	Allergies:
Treatment Instructions: Perform intermittent urinary catheterization utilizing ☐ clean technique ☐ sterile technique Special Monitoring: ☐ measure and record urinary output ☐ other (specify):	
Catheter size: _____Fr	Exact time or frequency:
Precautions: Contact the parent/guardian for signs of infection which may include cloudy urine, foul-smelling urine, blood in urine, and/or fever greater than 100 (not an all-inclusive list). Never use force when inserting the catheter. If force is needed, stop the procedure, and contact the parent/guardian.	
Student is competent to self-administer treatment ☐ yes* ☐ no ***Parent/guardian must complete the self-administration section on the back of this form.**	
Health Care Provider Name (print)	Provider Stamp
Address:	
Phone: / Fax:	
Health Care Provider Signature:	Date:
PARENT/GUARDIAN TO COMPLETE	
I authorize School Health personnel and, when appropriate, trained school staff to administer the above-stated treatment in accordance with school policies and Maryland State School Health Services Guidelines. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medical treatments at school. I have read the information on the back of this form and assume the responsibilities as stated therein. I understand that at the end of the school year, an adult must pick up the supplies, otherwise they will be discarded. I authorize the school nurse to communicate with the health care provider as allowed by HIPAA.	
Parent/Guardian Name (print):	Date:
Parent/Guardian Signature:	
Daytime Phone:	Other Phone:

Order reviewed by the School RN or LPN: _____ Date: _____

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TREATMENT GUIDELINES

These guidelines enable school health staff to provide the best possible service to your child.

1. The health provider order form must be completed and signed by the health care provider and the parent/guardian.

2. The parent/guardian is responsible for providing and maintaining all equipment and treatment supplies for the duration of the treatment order.

3. The school nurse or LPN must review and approve the written order prior to administration.

PARENT/GUARDIAN TO COMPLETE
Self-administration Conditions • Students that self-administer treatments must first have a written order from a licensed health care provider and written approval from the parent/guardian. • Once the written approvals are on file in the health office, the school nurse will conduct a nursing assessment to determine if the request to self-administer treatment can be safely executed. This includes an assessment of the student's competency in performing the treatment. • The school nurse will evaluate and reassess the student's competency to self-administer his/her treatment at specified intervals throughout the school year. • If the nurse observes the student performing the treatment in an unsafe manner, the student's ability to self-administer treatment will be discontinued until the plan is re-evaluated for safety.
I give permission for my child to self-administer his/her prescribed treatment during the school day and during school-sponsored activities. I have read and agree to the self-administration conditions listed above.
Parent/Guardian Name (print):
Parent/Guardian Signature: Date: