**TJ REGIONAL HEALTH SCHOOL-BASED MEDICINE PROGRAM**

**PRIMARY CARE PROVIDER (PCP) AUTHORIZATION: CATHETERIZATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLASSROOM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOSPITAL OF CHOICE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS AT SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRECAUTIONS AT SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERVENTIONS TO BE PROVIDED AT SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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RESTRICTIONS/EXCLUSIONS AT SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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OTHER COMMENTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

URINARY CATHETERIZATION: URETHRAL OR SUPRAPUBIC (ALL SUPPLIES/EQUIPTMENT ARE TO BE PROVIDED BY GUARDIAN).

TIMES FOR PROCEDURE: (SPECIFIC) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RECOMMENDED POSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF QUESTIONS REGARDING CATHETER TIMES, MAY WE CONTACT GUARDIAN FOR DECISION? \_\_\_YES \_\_\_ NO

CAN THE STUDENT CATHETERIZE SELF? \_\_\_ YES\_\_\_ NO

TYPICAL CHARACTERISTICS OF STUDENT’S URINE: \_\_\_ CLEAR \_\_\_ CLOUDY \_\_\_ ODOR \_\_\_ COMMON TO SEE BLOOD

TYPICAL COLOR & AMOUNT OF URINE OUTPUT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENCOURAGE WATER THROUGHOUT THE DAY? \_\_\_ YES \_\_\_ NO AMOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMEREGENCY PLAN OF ACTION:**

1. NOTIFIY GUARDIAN IF FEVER, STRONG ODOR FROM URINE, ABDOMINAL PAIN, PAIN OR SWELLING AROUND CATHETER SITEM URINE THAT IS DARK RED OR PINK, BLEEDING OF BLOODY DISCHARGE BEFORE OR AFTER PROCEDURE.
2. IF NECESSARY, NOTIFY SCHOOL PERSONNEL TRAINED IN CPR/FIRST AID TO RESPOND IF NEEDED PRIOR TO EMS ARRIVAL.
3. IF EMS IS CALLED, THE STUDENT MUST BE TRANSPORTED VIA EMS TO EMERGENCY FACILITY UNLESS PARENT/GUARDIAN SIGNS A RELEASE WITH EMS & ASSUMES RESPONSIBILITY OF STUDENT. THE STUDENT MAY NOT RETURN TO SCHOOL THAT DAY. IF STUDENT IS TRANSPORTED VIA EMS, STAFF MUST ACCOMPANY STUDENT UNLESS PARENT/GUARDIAN IS PRESENT TO ACCOMPAY THEM.
4. IF STUDENT REQUIRES MEDICAL TREATMENT WHILE ON THE BUS, THE BUS DRIVER WILL CONTACT 911.

**THIS ORDER & CARE PLAN IS FOR THE CURRENT SCHOOL YEAR. PARENT/GUARDIAN WILL SUPPLY ALL MEDICATIONS.**

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**PRINTED NAME OF PROVIDER PHONE NUMBER DATE**

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**SIGNATURE OF PROVIDER FAX NUMBER**

**ADDRESS OF PROVIDER**

**I GIVE PERMISSION FOR (STUDENT NAME) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO RECEIVE THE ABOVE STATED MEDICATION AT SCHOOL ACCORDING TO THE STANDARD SCHOOL POLICY. I RELEASE THE METCALFE COUNTY SCHOOL DISTRICT, TJRH & ITS NURSES FROM ANY CLAIMS OR LIABILITY CONNECTED WITH ITS RELIANCE ON THIS PERMISSION. (PARENT/GUARDIAN TO BRING MEDICATION IN ORIGINAL CONTAINER).**

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**PARENT/GUARDIAN SIGNATURE PHONE NUMBER DATE**

REVIEWED BY SCHOOL NURSE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_