Mesquite ISD Health Services

Authorization for Administration of Special Medical Procedure

To be completed at the beginning of each school year and kept on file with the school nurse.

Student Name: _____ Date of Birth: _____

Grade/Teacher: _____ School Year: _____

For Professional Healthcare Provider Use Only:

Diagnosis: _____

Type of Procedure:

____ Tube Feeding: ____ Gravity ____ Pump

Type: _____ Amount: _____

Flush Type: _____ Amount: _____

____ Tracheostomy Care

____ Emergency Trach Change

____ Suctioning ____ ml Normal Saline as needed for _____

____ Clean Intermittent Catheterization ____ Urostomy Pouch Change

____ Appendicovesicostomy ____ Colonostomy Pouch Change

____ Oral/Nasopharyngeal Suctioning ____ Other: _____

Description of "Other" Procedure: _____

_____

Scheduled Time/Interval for Procedure: _____

Self Administration only:

Does this student have physician permission for self-care?	_____ Yes	_____ No
Has this student been instructed and capable of doing the above procedure safely?	_____ Yes	_____ No
Does this student need the supervision of a designated adult?	_____ Yes	_____ No

This order will automatically expire one year from signature date.

Physician Signature: _____ Date: _____

Physician Printed Name/Stamp: _____ Phone Number: _____

For Parents:

This form must be completed annually and returned to the campus clinic for any student requiring administration of special medical procedure(s) during the school day.

Parents are responsible for providing any supplies needed to manage specific health conditions during the school day.

MISD protocols will be followed for the special procedures unless otherwise directed by the professional healthcare provider.

Non-healthcare school personnel may administer the prescribed procedure following training and successful evaluation of skills necessary for implementation.

In the event of an emergency, when campus personnel can not reach a designated contact person, Emergency Medical Services (EMS) will be activated.

I understand the information provided above and give my consent for the school nurse or other trained MISD personnel to administer to my child the medical procedure named above as prescribed by my child's physician.

Parent/Guardian Signature: : _____ Date: _____

Parent/Guardian Name (Printed): _____ Phone Number: _____

Revised 01/2011