

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: _____