PHYSICIAN ORDER FOR SCHOOL INTERMITTENT CATHETERIZATION

Student Name: _____ DOB: _____

School: _____ Grade: _____ School Year: _____

This Section to be Completed by PHYSICIAN:

Medical Diagnosis: _____

Pertinent Allergies: _____

Catheterization Order: (check applicable box)

☐ Intermittent Catheterization by School Nurse/Trained School Staff
☐ Intermittent Catheterization by Student (Self-Cath)
☐ Assistance or Monitoring Needed with Self-Cath

Frequency During the School Day:

Every _____ hours or specific times as listed: _____. _____. _____. _____. _____. _____

Output to be measured each time: ☐ Yes ☐ No | Latex Allergy: ☐ Yes ☐ No | Carries Own Emergency Supplies: ☐ Yes ☐ No

Additional Information about this procedure:

_____

In order to keep this child in optimum health and to help maintain school performance, it is necessary that this procedure be administered during school hours.

_____ _____
Physician's Signature Date

_____ _____
Physician's name (print) Phone

This Section to Be Completed by PARENT:

☐ As parent/guardian of the above named student, I request that the catheterization procedure as prescribed by the physician be administered at school.
☐ I agree to provide all the necessary supplies and equipment for the administration of the procedure.
☐ I understand it is my responsibility to notify the school if the orders change, and will provide updated physician orders.
☐ Unless otherwise specified, this order is good for the current school year and must be renewed each school year.
☐ My signature below indicates I am giving permission for the school staff to contact the physician for additional information, if needed.

_____ _____
Signature of Parent/Guardian Date

This resource provided by Association for the Bladder Exstrophy Community (A-BE-C).