Valid for school year _____

Photo (optional)

McKinney Independent School District
School Health Services

Physician Order/Parent Request for Administration of Special Procedure (W/O) PDN)

The school/campus nurse will review the order for safe implementation. The procedure(s) will be administered upon receipt of this completed and physician signed form *along with any special equipment and/or items required.* <u>*Please provide a copy of the student's current History/Physical/Well exam***.</u>**

Student _____ **Student ID** _____ **Campus** _____

Grade _____ **Teacher(s)** _____ **Date**_____ **Date of Birth**_____

Condition/Diagnosis: ☐ Cerebral Palsy ☐ Spina Bifida ☐ Other _____

Procedure(s) required for student while in the school setting (check/circle all that apply):

Diapering: _____
Diaper rash care: _____

Urinary Catheterization:
- Catheterize every _____hrs or at _____time(s)with _____Fr catheter
- Student may self catheterize- _____times a day or every _____hrs

Suctioning:
- Chest PT Vest _____
- Oral-as needed using a _____ suction catheter
- Tracheal-as needed: depth_____ cm
- Use 3-5 gtts saline prior to suctioning
- Trach Care ☐Yes ☐ No (If Yes, please see MISD Trach IHP form.)

Oxygen:
- Administer _____LPM via NC/mask/trach-collar <u>continuously</u>
- Administer _____ LPM via NC/mask/trach-collar <u>PRN</u>
- Administer _____ LPM via NC/mask/trach-collar at _____ (time of day)
- Administer _____ LPM via NC/mask/trach-collar for O2 Sats <u><</u>_____%
- Maintain O2 Sats between _____% using O2 via _____ @ _____ LPM
- Stoma/GT care: _____

Gastrostomy/Mic-Key Tube Feedings—**<u>Physicians orders required for ANY oral feedings when feeding tube(s) present. Aramark Food Services Dietary Accommodations Form AND/OR a letter from a physician may be necessary.</u>**
- Is student NPO (nothing by mouth)? ☐ Yes ☐ No (If NO letter required from physician)
- Type of diet required if trach or Gtube is present _____ (Modifications require Aramark Form)
- Supplement_____ Amount _____ Give every: _____hrs or at _____time(s)

  Give via: ☐Pump ☐ Gravity
  - ☐Give feeding at _____cc/hr
  - ☐ Check residual prior to feeding – If residual is more than _____ml
    - ☐Hold feeding _____minutes, recheck residual
    - ☐If residual more than _____ml, hold feeding & inform doctor and parents
    - ☐If residual less than _____ml, feed student as ordered
  - ☐ Flush with _____ ml water after feeding is complete
  - ☐ If Gastrostomy tube is pulled/falls out _____

**** McKinney ISD nurses and/or personnel DO NOT reinsert Gastrostomy/Mic-Key buttons/tubes***

Student _____**Student ID**_____ **Campus** _____

Shunt Care ☐ Yes ☐ No (If Yes, please see MISD Shunt Care IHP form.)

Additional Equipment/supplies needed **(to be provided by parent):** _____

Precautions needed if student is to ride school bus: (BUS #_____) _____

Other specific care (describe in detail):_____

_____

Circumstances in which the physician should be contacted: _____

It is impossible to schedule the above-mentioned medication/procedures at a time other than school hours. I request that this medication/procedure be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication/procedure. I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result.

I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education Right s and Privacy Act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

I request that the procedure(s) above be administered to my child according to the signed protocol from my physician. I hereby give permission for the school/campus nurse to consult with the prescribing physician or specialist regarding the order above.

Printed Name of Parent/Legal Guardian _____

Parent/Legal Guardian Signature_____ Date _____

Contact number(s) _____Work #_____

Based on the evaluation as a licensed physician, the above named student **requires the above health care service in order to attend school.** I certify that the student is under my continuing care. This care includes monitoring the student's continuing need for the service and any needed modifications of the services prescribed above.

Printed Physician's Name (print) _____ Date _____

Physician's Signature _____Phone _____ Fax _____

Nurse line/direct phone number _____

The following are a current list of my child's doctors and/or prescribing specialists for the procedures requested on this document. The Parent/Guardian will update this information as needed throughout the school year.

Primary Care Doctor:_____ Phone# _____

Genitourinary (GU) Doctor: _____ Phone# _____

Pulmonologist: _____ Phone# _____

Gastroenterologist (GI) Doctor: _____ Phone# _____

Other: _____Phone# _____

DME Company _____Phone # _____