Health Centers in Schools

Physician's/Parent Authorization for Special Health Care

Student: _____ Date of Birth: _____
School: _____
Address: _____ Phone# _____

Gastrostomy Feeding:

Name of Formula _____: Amount of formula per feeding _____
Infuse bolus feeding: _____ cc over _____ minutes; amount of water _____:
Administer feedings at (times) _____: Special Instructions and
Precautions: _____.
Should gastrotomy tube come out: _____.

Tracheostomy:

Suctioning: (catheter size and when and frequency) _____
Oxygen Needs: _____
Trach replacement: (included size for trach) _____
_____.
Special Instructions and Precautions: _____.

Catheterization:

Times for catheterization:
Specific Instructions: _____
Modifications for time of procedure in the event of a field trip: _____
Other Procedure and Orders: _____
The procedure is to be performed by:
( ) Nurse/trained staff
( ) Student

_____ _____
Physician Signature Date

_____ _____
Print Name Phone

I hereby request that the ordered procedure be performed to the named student.

_____ _____
Signature of Parent/Guardian Date

I released those persons designated by our physician to perform the procedure from all liability. I understand that whenever possible specialized health procedures should be provided before and after school.

_____ _____
Signature of Parent/Guardian Date