Medical Authorization for Special Health Care

Student: ______________________________ Date of Birth: ____________

School: ______________________________ School Year: ____________

Phone#(s): ____________________________

Primary Diagnosis Code (required): ________________

Gastrostomy Feeding:

Formula:____

□ Gravity Bolus

Amount of formula per feeding: _______________; Amount of water: ________

Feeding Time(s): _______________

Please note: EBR elementary schools dismiss at 3p and middle/high schools dismiss at 2:30p.

□ Bolus via Feeding Pump

Infusion Rate: _______ cc over _______ minutes; Amount of water: ________

Feeding times: ____

Please note: EBR elementary schools dismiss at 3p and middle/high schools dismiss at 2:30p.

□ Continuous Feeding via Pump

Infusion Rate: _______ cc Feeding Start and/or Stop Time: _______________

Special Instructions/Precautions: ____________________________________

Should Gastrotomy Button/Tube be accidentally removed: ______________________

Tracheostomy:

Suspending (catheter size, depth, and frequency): _____________________________

____

Oxygen Needs (if applicable): ____

Size(s) of Replacement Trach: ____

Special Instructions/Precautions: ____

Please note: If a student has a tracheostomy (and a ventilator, if applicable), please contact the Department of Health Services at jduvic1@ebrschools.org or (225) 317-8703 to allow us to coordinate trach training(s), to provide the school go-bag checklist, and to review trach/vent orders.

Other Respiratory:

□ Oxygen Needs:____

□ Oral Suctioning (catheter size, depth, and frequency): _____________________________

□ Nasal Suctioning (catheter size, depth, and frequency): ____________________________

Catheterization:

Times for catheterization: ____

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Specific Instructions: ____

Modifications for field trip(s): ____

Other Procedure(s) and Order(s): ____

____

The prescriber recommends that the outlined procedure(s)/service(s) above be performed (in the school setting) by: ☐ Nurse/Trained Staff ☐ Student ☐ Parent/Guardian

____ ____________________

Signature of Physician/Licensed Healthcare Provider Date

____ ____________________

Printed Name and NPI# Phone/Office#

I hereby request and authorize the school nurse/trained staff member(s) (under the school nurse's supervision) to perform the medically prescribed procedure(s), as outlined above. I release individuals that are trained to perform the prescribed procedure(s), as outlined above, from all liability in performing said procedure(s) to meet my child's healthcare needs. I understand that, whenever possible, specialized healthcare procedures should be provided in the home setting (before/after school hours).

____ ____________________

Signature of Parent/Guardian Date