Learning to Live • Loving to Learn
ACPS
Alexandria City Public Schools

Physician / Parent Authorization for Administration of Special Procedures
School Year_____

The school nurse will review this form to ensure completion and correct dates. Specialized health care will be provided when this form is completed in its entirety by both the physician and the parents/guardians.

Student _____DOB _____ Age _____

Grade_____ School_____ Medicaid Eligible: yes_____ no____ permission to bill_____

Conditions/Diagnoses: _____

The following procedure(s) is/are required for this student while in the school setting (check all that apply):

__ **Suctioning**: __ Oral (PRN) __ tracheal (PRN) – depth ____ cm. Use 3-5 gtts saline prior to suctioning)

__ **Oxygen:**___ LPM via NC/mask/trach collar, continuous/PRN or at _____ for _____.
(circle one) (circle one) (time of day) (condition)
___ Give PRN for oxygen saturations < _____ and continue checking pulse ox

__ **Nebulizer Treatments:** Give via mask/hand-held/trach collar/_____ (identify mode)
(circle one)
____Give (med)_____ q _____hrs. x _____ days/ongoing

__ **Tracheostomy Tube:** reinsertion PRN

__ **G-tube Feedings:** via NGT/G-tube/Jejunostomy/ Other: _____
__ Gravity Feed __ Pump: set at _____ gtts / minute / hour __ Slow push over_____ min/hr

__ Give _____cc of _____ at _____ AM/PM _____ AM/PM _____ AM/PM
__ Flush / irrigate with _____ cc of water after each feeding
__ Check for residual prior to each feeding. If there is _____ cc residual, hold feeding for _____ minutes then re-check residual. If more than ____ cc, hold feeding and inform MD and parents/guardian if less than _____cc, feed student as ordered
__ G-tube reinsertion PRN, or as noted here: _____
__ Other_____

Feeding Instructions:
Positioning: _____Amount of food per bite_____
Equipment: _____Keep student upright for _____minutes after meal

Diet / Food Preparation:
Food Consistency: Pureed___ Ground___ Chopped___ Mashed___ Bite Size___
Liquid Consistency: No liquids___ Thin liquids___ Thickened liquids ____
Other: _____
__ Other Feeding recommendations: _____

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__ **Catheterization: Catheterize / Self-Cath** at _____AM/PM _____ AM/PM
(circle one)

__ **Diaper Change:** at _____ AM/PM _____ AM/PM PRN (circle if PRN)

__ **Vagal Nerve Stimulator/Seizure Management**
__ Swipe VNS at onset of seizures: then every _____min. x _____ min. or until seizures stop.
__ If seizures last more than _____ min. give (med) _____mg. PR/Sublingual/PO
__ If rectal medication is expelled, do the following: (circle one)
_____
__ Call 911 if seizures lasts more than _____ minutes.
__ Call 911 if _____

__ **Blood Pressure Monitoring:** Frequency: _____ Duration: _____
If BP is >than _____, inform MD and/or parent/guardian
If BP is < than _____, inform MD and/or parent/guardian

__**Blood Sugar Monitoring** (outside of the diagnosis of diabetes) Frequency: _____
__Give 15 gm CHO and recheck BS in 15 minutes
__Call MD or parent if BS is < _____after CHO is given twice.
(circle)
__Other Procedures (Describe):_____
_____

I, the undersigned, parent/guardian of _____ request that these
Student's Name
procedure(s) be administered to my child. I authorize the school nurse to contact my child's physician as per the call orders on this authorization form. I will notify the school immediately if the health status of my child changes, there is a change in physicians, or there is a change or cancellation of the procedure(s).

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Phone# (Home) Work # Cell #

_____ _____
Physician's Name Date of Signature

_____
Signature

_____ _____
Address Date orders expire

_____ _____
Phone # Fax #

9.4.14