

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR CLEAN INTERMITTENT CATHETERIZATION

School Year: _____ - _____

STUDENT INFORMATION

Student's Name _____ School: _____

Date of Birth: ____ / ____ / ____ Age: ____ Grade ____ Teacher _____

Known drug allergies If drug allergies, please list: _____ Weight: _____ lbs

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider.)

ALL ORDERS ARE GOOD FOR ONE CALENDAR YEAR UNLESS OTHERWISE NOTED WITH "STOP DATE"

START DATE: _____

STOP DATE: _____

<u>Size of Catheter</u> _____ Fr.	<u>Frequency/Time(s)</u> _____	<u>Measure & Record Output?</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Location for Procedure:</u> <input type="checkbox"/> Nurse's office bathroom <input type="checkbox"/> Other: (Describe) <input type="checkbox"/> Classroom bathroom
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Storage: Catheter will be discarded after each use, unless other instructions provided.

Self care is permitted and recommended for this student? Yes No

- If "no", procedure is to be completed: By School Nurse With Assistance from School Nurse Supervised by School Nurse
- If "yes", do you recommend equipment, supplies be kept "on person" by the student? Yes No

I hereby affirm that this student has been instructed in the proper technique for self-care related to his/her clean intermittent catheterization procedure.

_____ (Initials)

Potential Contradictions/Adverse Reactions

Printed Name of Licensed Healthcare Provide _____

Signature of Licensed Healthcare Provider _____ Date _____ Phone _____ Fax _____

PARENT AUTHORIZATION

I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment or supplies must be registered with the school nurse or his/her designee.

Signature of Parent _____ Date _____ Phone _____ Cell _____

SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

Signature of Parent _____ Date _____ Phone _____

