



Physician / Parent Authorization for Administration of Special Procedures

The School Nurse will review the order & ensure that it is completed & dated. Specialized health care will be provided when this form is completed in its entirety by both physician(s) & parents/guardians.

Student _____ ID# _____ Date of Birth _____ Age _____ Grade _____

Teacher _____ Campus _____

Condition/Diagnosis: _____

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

Suctioning: Oral (as needed) tracheal (as needed – depth _____ cm. Use 3-5 gtts saline prior to suctioning)

Oxygen: Give _____ LPM via NC/mask/trach collar, continuous/PRN or at _____ for _____.
(Circularnuous/ ~~Re65~~)

Blood Pressure Monitoring: Frequency: _____ Duration: _____

If BP is greater than _____, inform MD and parent/guardian

If BP is less than _____, inform MD and parent/guardian

Other: (Describe): _____

Infusion Therapy: _____ Heplock _____ PICC _____ Central Line & Type _____ Other: _____

Pump Setting: _____ gtts / minute / hour (if applicable)

Fluid to be infused & volume _____

Infusion Times: _____ hours / day Flushing (n) bed(F)1..7(u)-25 (hd0c 0Tmn/-)43 (&-ni114T2-4)/da5h0T7A88/() Ts