



PHYSICIAN ORDER FOR SCHOOL INTERMITTENT CATHETERIZATION

Student Name: _____ DOB: _____
School: _____ Grade: _____ School Year: _____

This Section to be Completed by PHYSICIAN:

Allergies: _____
Medical Diagnosis: _____
Catheterization Order: (check applicable box)

- Intermittent Catheterization by School Nurse/Trained School Staff
- Intermittent Catheterization by Student (Self-Cath)
- Assistance or Monitoring Needed with Self-Cath

Frequency During the School Day:

- Every _____ hours
- Specific Times as listed: _____

Output needs to be measured each time: Yes No

Additional Information about this procedure:

In order to keep this child in optimum health and to help maintain school performance, it is necessary that this procedure be administered during school hours.

_____ Physician's Signature	_____ Date	
_____ Physician's name (print)	() _____ Telephone Number	() _____ Fax Number

This Section to Be Completed by PARENT:

- As parent/guardian of the above named student, I request that the catheterization procedure as prescribed by the physician be administered at school.
- I agree to provide all the necessary supplies and equipment for the administration of the procedure.
- I understand it is my responsibility to notify the school if the orders change, and will provide updated physician orders.
- Unless otherwise specified, this order is good for the current school year and must be renewed each school year.
- My signature below indicates I am giving permission for the Conroe ISD School staff to contact the physician for additional information, if needed.

_____ Signature of Parent/Guardian	_____ Date	() _____ Telephone Number
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(for Health Office Use Only) _____ School Nurse _____ Review Date