WASHINGTON COUNTY DEPARTMENT OF EDUCATION
Coordinated School Health
University School

Phone: (423) 439-8674 Fax: (423) 439-5921

Student Name: _____ DOB: _____

This Section to be Completed by PHYSICIAN:

Allergies: _____

Medical Diagnosis: _____

Catheterization Order: (check applicable box)

☐ Intermittent Catheterization by School Nurse

☐ 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:

_____

_____

Physician's Signature:_____ Date:_____

Physician's Name (Print): _____ Phone:_____ Fax:_____

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 WCDE staff to contact the physician for additional information, if needed.

Signature of Parent/Guardian:_____ Date: _____ Phone:_____

(For Health Office Use Only) _____ School Nurse _____Review Date