Authorization For Clean Intermittent Catheterization (CIC) Or Assisted Self-Catheterization at School

Date of Plan_____

Order is valid for entire 20___- 20___ school year to include summer school

Student Name: _____ Birthdate: _____

Allergies: _____

School: _____

Phone: _____ Fax: _____

This portion is to be completed by a licensed Healthcare Professional

Diagnosis for Catheterization:	
Type of Catheterization:	[ ] Clean Intermittent or [ ] Assisted Self-Catheterization
Time/Schedule:	
Precautions and interventions:	
Catheter type and size:	
Medications required:	

An additional medication administration form will need to be filled out and signed if medications are required.

Attached Authorization for Administration of Medication at School Form? [ ] Yes [ ] No

Additional orders or instructions: _____

_____

I request and authorize that the above named student be provided CIC in accordance with the instructions indicated above. This order is valid during school hours or during such times the student is under the supervision of school officials.

_____ _____

Provider Name Provider Signature

_____ _____ _____

Date Contact Number Fax Number

This portion is to be completed by the Parent/Legal Guardian

By signing this form, I agree to all of the above information and I am explicitly requesting that a nurse or parent designated adult administer care to my child while under the supervision of the school.

_____ _____

Parent/Legal Guardian Name Parent/Legal Guardian Signature

_____ _____ _____

Date Parent/Legal Guardian Primary Contact Parent/Legal Guardian Secondary Contact