RACINE UNIFIED SCHOOL DISTRICT
Health Services
Ostomy Care at School

PARENT/GUARDIAN REQUEST:

Student's Name:_____ Date of Birth:_____
Please Print

Parent/Guardian's Name:_____ Date Requested:_____

I request that my child, named above, receive the following procedure at school using the doctor's orders written below. I give permission for the school nurse to contact the doctor or the doctor's representative to clarify any questions about the procedure. I understand that this procedure requires a new order each school year or if there is any change. I understand that I am responsible for providing all supplies related to this procedure.

Procedure: ☐ **Colostomy Care** ☐ **Ileostomy Care** **Latex Allergy:** ☐ YES ☐ NO

Parent/Guardian's Signature:_____

PHYSICIAN'S ORDERS:

Student's Name:_____ Date of Birth:_____

Physician's Name:_____ Phone Number:_____

Address:_____ Fax Number:_____

I authorize that the student named above receives ostomy at school per the orders below. I understand that a school district employee(s) trained by the school nurse following school district protocols will perform or assist with the procedure as needed.

Length of Order: ☐ Full School Year/Summer School ☐ From_____to_____

Procedure is: ☐ Colostomy care ☐ Ileostomy care ☐ Clean ☐ Sterile

Latex Precautions: ☐ Yes ☐ No

Student Needs: ☐ Someone to perform the procedure for them ☐ Assistance only ☐ Independent

For skin breakdown use:_____

_____

I want to be notified if:_____

_____

Does this order replace a previous order: ☐ No ☐ Yes If yes, the previous order will be discontinued.

Comments:_____

_____

Physician's Signature: _____ **Date**: _____
