



RACINE UNIFIED SCHOOL DISTRICT
Health Services
Intermittent Urinary Catheterization 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: [ ] Intermittent urinary catheterization 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 an intermittent urinary catheterization 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: [ ] Clean [ ] Sterile

Latex Precautions: [ ] Yes [ ] No

Frequency of catheterization: \_\_\_\_\_

Type and Size of Catheter: \_\_\_\_\_

Student Needs: [ ] Someone to perform the procedure for them [ ] Assistance only [ ] Is independent

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: \_\_\_\_\_