

**Medical Authorization for Management of Urinary Catheterization at School**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School Name: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Medical Diagnosis: \_\_\_\_\_

Place  
student  
photo here

**Complete this section for intermittent catheterization:**

☐ Intermittent catheterization via Mitrofanoff ☐ Intermittent catheterization via Urethra

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

Schedule of Intermittent Catheterization:

- ☐ Every \_\_\_\_\_ hours  
☐ At specific times: \_\_\_\_\_  
☐ As needed for: \_\_\_\_\_

Output needs to be measured: ☐ Yes ☐ No

- ☐ Intermittent catheterization completed by School Nurse or trained school staff  
☐ Student can independently self-catheterize

Student requires staff supervision during self-catheterization: ☐ Yes ☐ No

Other related instructions (e.g. specific supplies needed, positioning, when to notify family, etc.): \_\_\_\_\_

**Complete this section for indwelling catheter:**

☐ Indwelling Foley catheter ☐ Suprapubic catheter

Size of Catheter: \_\_\_\_\_

Schedule for Indwelling Catheter:

- ☐ Empty urine bag every \_\_\_\_\_ hours  
☐ Remove stopper/unclamp to drain catheter every \_\_\_\_\_ hours

Other related instructions: \_\_\_\_\_

Output needs to be measured: ☐ Yes ☐ No

*I authorize and provide medical justification for the above-named student to receive care related to catheter during school hours. This is necessary for the management of a medical condition and to ensure the student's health and safety.*

**Healthcare Provider Information (with prescriptive authority):**

Provider Name (Print): \_\_\_\_\_ Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Parent/Guardian Consent:**

*I understand that intermittent catheterization and/or catheter care is a necessary health service for my student during school hours. I give my consent for trained school personnel to perform this procedure as directed by the healthcare provider above and, if necessary, contact our health care provider regarding this order. I agree to provide the necessary catheterization supplies and to update the school with any changes in my student's condition or treatment plan.*

Parent/Guardian Name (Print): \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**School Nurse/CCHC:**

School Nurse/CCHC (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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