**School Year:** _____

# 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: _____

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**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: _____

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**School Nurse/CCHC:**

School Nurse/CCHC (Print): _____ Signature: _____

Date: _____