



**Prince George's County Public Schools
Department of Student Services
HEALTH SERVICES**

**Prescriber's Orders for Specialized School Health Services
(Catheterization)**

School: _____ School Year: _____

Name of Student _____ (DOB: _____)

REFERRAL	Health Services Nurse		Phone
	Physician's Name		Phone
	Physician's Address		
PATIENT INFORMATION	Patient Name (Last, First, Middle Initial)	Date of Birth	Race
	Patient Address	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone
	Parent or Guardian	Relationship to Child	Phone
	School Presently Attending		Phone
PHYSICIAN'S ORDERS	Diagnosis/Pertinent History (Use back as needed)		Treatment Start Date
			Treatment End Date
	Describe Treatment/Procedure to be Administered: CLEAN INTERMITTENT CATHETERIATION AT SCHOOL		
	Frequency: _____		
	Times: _____		
	Special Instructions:		
	Equipment/Supplies Necessary for Procedure		
	Catheter size: _____, wipes, lubricant, receptacle for urine. Special Equipment:		
Dietary Recommendations			
Activity Limitations			
Physician's Signature		Date	
PARENT/GUARDIAN	<ul style="list-style-type: none"> • I understand that I must supply the school with the equipment/supplies listed above. • I hereby authorize the treatment/procedure described above to be administered by Prince George's County Public School's staff to my child as directed by my child's physician. • I understand that the physician will be called if a question arises about my child's procedure. 		Date
	Parent Signature		Date
PGCPS	RN/LPN Signature		Date