

GCS Health Services Medical Procedure Authorization Form

Student Name: _____ Date of Birth: _____
 Medical Diagnosis(es): _____ Allergies: _____

Airway

Start Date: _____ End Date: _____
Suctioning: Nasal Nasopharyngeal Oral Tracheal
 Frequency: _____ Size of Catheter: _____ Length/Insertion depth(cm): _____
 Other respiratory procedure/frequency: _____
Tracheostomy Type and size: _____ Uncuffed Cuffed(water/air: _____ml)
Oxygen: _____ Face Mask Nasal Cannula Other
CPAP: _____
Additional Instructions: _____
Pulse Oximetry: Continuous Intermittent Checks: _____

Nutrition

Start Date: _____ End Date: _____
Type of Tube: Nasogastric(NG) Gastrostomy(GT) Combo(Jejunostomy/Gastrostomy (GJ))
 FR Size/Length: _____ Balloon Volume: _____
Formula: _____ Continuous Bolus
 Volume: _____ By Gravity By Pump
 Rate: _____ (ml/hr)
 Scheduled Time(s): _____ Pump Type: _____
Water flush/Amount: After feeds: _____ (ml)
 Scheduled: _____ (ml) Time(s): _____

Elimination

Start Date: _____ End Date: _____
Continuous Indwelling Catheter (CIC): Size: _____
 Frequency/Time: _____
Intermittent Catheterization: _____ Size: _____
 Frequency/Time: _____
 Student may perform catheterization: Without nursing supervision* Requires nursing supervision
*If student will perform self-catherization independently, licensed healthcare provider and parent must also complete MED-2 Self-Administer Authorization Form
Other: _____

Additional Procedures: Blood Pressure Check Blood Glucose Check Other: _____
 Start Date: _____ End Date: _____ Time of day: _____
 Additional Information: _____

Printed Name of Licensed Health Care Provider: <small>(Print or stamp is acceptable)</small> Office Address:	Phone: Fax:
Signature of Licensed Health Care Provider:	Date:

Parent/ Legal Guardian please read carefully:

- I will notify the school when the procedure is discontinued or there are changes
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child
- I give GCS Health Services my permission to contact the above named Licensed Health Care Provider
- I am responsible for replacing supplies as requested
- I give my permission for designated GCS staff to provide care to my child according to district requirements

Parent/Legal Guardian's Signature: _____ Date: _____
 Parent/Legal Guardian's Printed Name: _____ Phone Number: _____