



Physician/Parent Request for Administration of special Procedures

Student Name: _____ DOB: _____ Date: _____

The school nurse (RN) will review the order for safe implementation. This specialized health care procedure will be administered upon receipt of this completed form along with any special equipment items.

Condition / Diagnosis:

- Seizures
- Cerebral Palsy
- Spina Bifida
- Other: _____

Procedure(s) required for student while in the school setting (check all that apply and sign/date each section that applies).

Suctioning:

- Oral – as needed
- Trachael – as needed: depth _____ cm, size _____ Fr.
 - Use _____ saline prior to suctioning

Oxygen:

- Give _____ LPM via NC / Mask / Trach-collar
 - Continuous / PRN or at _____ for _____.
- Time of day Condition

Nebulizer Treatments: Give via _____.

- Give _____ q _____ hours x _____ days / ongoing.
- Give PRN for oxygen saturations < _____ q _____ hours x _____ times.

Vent Settings: _____

Physician/Health Care Provider's Name (Printed): _____

Physician/Health Care Provider's Signature: _____ Date: _____

Gastrostomy tube feeding:

- Flush with

Diapering:

Urinary Catheterization:

VNS/Seizure Management

PRN Medications: