Baltimore City Health Department **BUREAU OF SCHOOL HEALTH**	**ORDERS MODULE: Authorization to Administer Treatment/Procedure in School – (Multiple Orders)**

This order is valid only for the (current) school year _____including the summer session.

Student Name: _____ Grade/Class: _____ School # _____

Birth Date: _____ School Year:_____

GASTROSTOMY FEEDING	( ) PUMP	( ) GRAVITY	TIME MAX – 1HR.
	Formula: _____ Vol.: _____Rate: _____Water Vol.:_____ GT TUBE REPLACEMENT: ( ) When no longer patent ( ) When dislodged Type of Tube:_____ Size:_____ Balloon Size:_____		
	COMMENTS:		
SUCTION	( ) Nasal ( ) Oral ( ) Pharyngeal ( ) Tracheostomy ( ) Bulb ( ) Catheter Size_____ ( ) Routine Time: _____ ( ) PRN - Frequency:_____		
	COMMENTS:		
CATHETERIZATION	( ) Urethral ( ) Ostomy Catheter size_____ Time(s) in School:		
	COMMENTS:		
OSTOMY CARE	( ) Colostomy ( ) Ureterostomy ( ) PRN – Frequency: _____ Type of Appliance: _____ Specific Instructions: _____ _____		
	COMMENTS:		

_____ DATE	_____ Healthcare Provider's Signature _____ Type/Print Name/Address of Healthcare Provider	_____ Office # _____ Fax #

PARENT/GUARDIAN AUTHORIZATION

I understand that designated school health staff will administer the treatment/medication as prescribed by the above healthcare provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the equipment and/or medication, otherwise it will be discarded. I acknowledge that the school nurse can communicate with the healthcare provider as allowed by HIPAA.

Parent (Guardian) Signature: Relationship To Student: Date:

Date received in health suite: by:

Order reviewed by School Nurse (Print): Signature: Date: