## Durham Public Schools

## Parent Request and Provider Order Form for Skilled Nursing Procedure

This form should be used only when school personnel will be administering a skilled nursing procedure to your child

**Student Name:** _____ **DOB:** _____ **School:** _____

In order to help protect your child's health, your consent and written authorization from a Health Care Provider are required when it is necessary for your child to receive a skilled nursing procedure in the Durham Public Schools. No skilled nursing procedures will be administered to your child at school until this authorization has been received. A separate from is required for each procedure. New authorization forms are required every year at the beginning of school, whenever there are changes, when a new procedure is prescribed, or on re-entry after hospitalization.

I _____ understand that:

- It is my responsibility to purchase and supply all supplies needed to perform the procedure at school.
- The Durham Public Schools Board of Education and its employees and agents authorized to administer the procedure prescribed by a doctor upon my written request shall not be liable in civil damages for an administration or for any omission relating to the administration, unless that act or omission amounts to gross negligence, wanton conduct, or intentional wrongdoing.
- Information shared may be in the form of an emergency or individual care plan for my child and may include information provided by my child's healthcare provider, myself, or from records that have been released to the school from another agency.
- Exchange of information will be limited to the minimum necessary to provide the required assistance for my child and will be shared only with those staff who may need to provide the required assistance for my child and will be shared only with those staff who may need to provide the specified assistance for him/her.
- This consent to release information must be signed before my child's teachers can provide assistance with special medical needs other than notifying parents and providing Emergency Services (911).
- If my child participates in DPS before/after-school activities/sports, I will assume responsibility for notifying the advisor/coach of my child's medical condition. Since the medication/supplies kept by the school is only available during regular school hours, I will provide extra emergency medications/supplies that may be needed during the activity. I may contact the school nurse if assistance is need in instructing the advisor/coach in a medical procedure or if a copy of the information needs to be shared with them.

I, _____, authorize the release and exchange of medical information between my child's healthcare provider, school nurse and Durham Public Schools that is necessary in carrying out services for my child, _____.

I, _____, also hereby give permission for my child _____ to be administered the specified procedure/medication indicated by his/her healthcare provider on the reverse. I understand that non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique. I understand that it is my responsibility to transport the supplies/medication to school unless special arrangements are made with the principal.

_____ _____

**Parent/Guardian Signature** **Date**

**Parent/Guardian Name:** _____ **Phone:** _____

**Emergency Contact Name:** _____ **Relationship:** _____ **Phone:** _____

**DPS Employees Designated and Trained to Perform Procedures/Give Medications**

| Name | Title | Name | Title |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Signature of Principal: _____ Date: _____

**Durham Public Schools**

**Parent Request and Provider Order Form for Skilled Nursing Procedure**

**Student Name:** _____ **DOB:** _____ **School:** _____

☐ Please check if this is an emergency procedure, also provide an Emergency Action Plan

| Name of Procedure | Purpose | Time(s) or PRN | Side Effects | Description of Skilled Procedure |
|---|---|---|---|---|
| **G-tube bolus by gravity**<br>Formula: _____<br>Amount (formula): ____mL<br>Amount (H20 flush): ___mL | | | | |
| **G-tube feed by pump**<br>Formula: _____<br>Rate: _____mL/Hour<br>Volume: _____mL<br>Flush: _____mL | | | | |
| **Vagal Nerve Stimulator** | | | | |
| **Intermittent Bladder Catheterization**<br>Catheter size: ____ (Fr) | | | | |
| **Other Procedure:** | | | | |

I _____ (Provider Name) state that it is necessary for this student to receive this procedure and/or medication during school hours in order to maintain or improve health and benefit from school attendance.

**Practice Stamp/Contact Information**

_____ _____

**Healthcare Provider Signature** **Date**

_____ _____

**Parent/Guardian Signature** **Date**