Prince George's County Public Schools
Prescriber's Order Form for

Specialized Treatments Order Form

This order is valid ONLY for the school year (current) _____ including the ESY/summer session.

PART 1: PARENT/LEGAL GUARDIAN TO COMPLETE		
Student's name:		Birthdate:
School:		Grade:
Parent/Guardian Name (print):		
Home phone #:	Cell phone #:	Work phone #:
Known Allergies: □ None	□ Specify:	
• **I** hereby authorize the procedure/treatment described below to be performed as directed by my child's health care prescriber. • **I** understand that the prescriber will be called if a question arises about my child's procedure/treatment as allowed by HIPAA. • **I** understand that I must supply the school with the equipment/supplies needed to perform procedure/treatment. • **I** understand that at the end of the school year, an adult must pick up the equipment/supplies, otherwise it will be discarded.		
Parent/Guardian Signature:		**Date:**

PART 2: LICENSED PRESCRIBER TO COMPLETE			
Medical Condition(s):			
Treatment/procedure start date (**month/day/year**):		Treatment/procedure end date (**month/day/year**):	
□ **CLEAN INTERMITTENT CATHETERIZATION AT SCHOOL (CIC)**			
Catheter size:	Frequency:	Time(s):	
Special Instructions:			
□ **OSTOMY**			
Pouch/bag type:		Pouch/bag size:	
Special skin precaution procedure:			
□ **SUCTIONING**			
Type: □ Nasal □ Oral □ Tracheal	Catheter size: Suction Depth:	Suctioning time(s):	
Tracheostomy Type:	Cuffed: □ Yes □ No	Trach size: Back-up size:	
Ventilator: □ Yes □ No Ventilator Type: Ventilator Settings:	CPAP: □ Yes □ No CPAP Settings:		
Oxygen: □ Yes □ No	Oxygen Settings:	Delivery Method: □ NC □ FM □ TM	
Diaphragmatic pacer: □ Yes □ No			
Special Instructions:			
□ **TUBE FEEDING**			
Feeding tube type: □ Nasogastric □ Gastrostomy □ Gastro-Jejunum □ Other:		Tube size:	

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Formula type:		Formula amount to be delivered:
Formula may be substituted as needed with:		
Delivery method: □ Pump □ Gravity		Pump type:
Time(s):	Rate of delivery:	Flush amount:
May replace tube: □ Yes □ No	Size of replacement tube:	Balloon fill _____cc/ml

Special Instructions:

1. Feeding will run a minimum of 20-30 minutes. Students will be in a sitting position, unless otherwise instructed.
2. In the event of abdominal distention, gagging or emesis, feeding will be discontinued and parents contacted for further instructions. Carbonated beverages may be used to flush tubing in case of clogging. Decompression may be used to vent the button.
3. In the event the GT Mic-KeY /MiniOne Button gets dislodged, the school nurse may re-insert the same size GT Mic-Key or MiniOne student is currently using. If unable to re-insert GT cover site with dry gauze and contact the parent immediately.
4. Other:

*Note: G/J, J-Tubes and PEG Tubes are inserted by a physician only and cannot be changed by a nurse.

□ VAGUS NERVE STIMULATOR (VNS)

*PLEASE NOTE: 911 will be called immediately for:

1. Seizure lasting longer than 5 minutes
2. Repeated seizures occurring one after another
3. Difficulty breathing occurring with any seizure

Magnet to be used with VNS: □ Immediately after start of seizure □ Seizure lasting greater than _____minutes

If seizure still ongoing after initial use, may repeat magnet swipe over VNS in: □ _____ Seconds □ _____ Minutes

Special Instructions:

□ WOUND CARE

Type of Wound:	Type of dressing:	Dressing change time(s):

Dressing procedure/instructions:

□ OTHER MEDICAL DEVICES

□ Ankle Foot Orthosis (AFOs) □ Braces □ Scoliosis brace □ Slings □ Splints □ Other:

Special Instructions:

Prescriber's Name/Title (printed):	NPI#
Prescriber's office phone #:	Prescriber's office fax #:
Prescriber's office address:	
Prescriber's Signature: (**Original Signature or signature stamp only**)	Date:
Order reviewed by RN/LPN:	Date:

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Plan of Care for School Attendance

Medications needed during the school day (scheduled and PRN): □ YES □ NO (if yes, a prescriber order form needed for each)

DME and Supplies:

Safety Measures:

Functional Limitations:
□ Amputation □ Paralysis
□ Legally Blind □ Bowel/Bladder (incontinence)
□ Endurance □ Contracture
□ Ambulation □ Depressed
□ Hearing □ Speech
□ Agitated □ Dyspnea w/minimal extortion
□ Other (specify):

Activities Permitted:
□ Up as Tolerated □ Wheelchair
□ Transfer Bed/Chair □ Walker
□ Exercise prescribed □ No restrictions
□ Partial weight bearing
□ Crutches
□ Cane
□ Other (specify):

Mental Status:
□ Oriented □ Comatosed □ Forgetful □ Depressed
□ Disoriented □ Lethargic □ Agitated □ Other (specify):

Prognosis: □ Poor □ Guarded □ Fair □ Good □ Excellent □ Other (specify):

Orders for Discipline and Treatments (specify amount/frequency/duration) not identified in medication or specialized procedures and treatments orders required during the school day:

Physician's Name, Address and Phone number:

NPI:

I certify that this patient requires skilled nursing services while attending school. This patient is under my care and I have authorized the services on this plan and will periodically review and update as needed.

Attending Physician's Signature and Date Signed:

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