Primary Care Provider Authorization: Catheterization

Student: ___________________________ Date of Birth: _________________

School: ________________________________ School Year: __________________

Times(s) for procedure: ____

Recommended position: ____

____

Health Care provider's comments: ____

	Primary Care Provider: Describe typical characteristics	Parent/Guardian: Describe typical characteristics
Urine *Clear/Cloudy *Color/Blood *Odor *Amount		
Student *Temperature *Comfort *Fluid intake		

Other health care provider's comments: ____

____

***Please note: When any changes in the student's typical characteristics (listed above) are observed, the parent/guardian must be notified immediately.**

****Latex Allergy:** ☐ Yes ☐ No

____________________________ ____________________________

Printed MD, ARNP, or PA Address

____________________________ ____________________ ____________________

Signature of MD, ARNP, or PA Telephone No. Date

*** Note to parent/guardian: Signing this form shall release the ______________Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.**

____________________________ ____________________ ____________________

Signature of Parent/Guardian Telephone No. Date

____________________________ ____________________ ____________________

Emergency Contact Telephone No. Relationship

Source: Jefferson County Public Schools Health Services