CUMBERLAND COUNTY SCHOOLS
PHYSICIAN'S HEALTH CARE ORDERS FOR SCHOOL **Rev. 6/2013**

Name of School: _____

Name of Student: _____ Grade: _____ Date of Birth: _____ Age: ____

PROCEDURE:

☐ **Blood Pressure**

Frequency:_____ If blood pressure is greater than:____ or less than: _____ then _____

Physician's comments, additional orders and/or precautions: _____

_____

☐ **Clean Intermittent Catheterization**

Frequency:_____

Physician's comments, additional orders and/or precautions: _____

_____

☐ **Tube Feedings (Enteral Nutrition)**

Frequency:_____ If residual is greater than or equal to_____, then_____

Type: ☐ Gastrostomy ☐ Nasogastric ☐ Other:_____

Formula: _____ Amount: _____ Amount of water to flush: _____

May replace feeding device if displaced at school. ☐ Yes ☐ No

Physician's comments, additional orders and/or precautions:_____

_____

☐ **Tracheostomy Care**

Frequency:_____ or ☐ prn only

If trach is displaced, follow this plan of action. _____

Physician's comments, additional orders and/or precautions: _____

_____

☐ **Suctioning** Type: ☐ Nose ☐ Mouth ☐ Trach

☐ Tracheostomy

Frequency:_____ or ☐ prn only

☐ Bulb syringe

Frequency:_____ or ☐ prn only

Physician's comments, additional orders and/or precautions: _____

_____

☐ **Dressing/Wound Care**

Frequency:_____ Instructions:_____

_____

Physician's comments, additional orders and/or precautions: _____

_____

Notice: If any of the procedures require medication, complete a Cumberland County Schools Physician's School Medication Form.

If an emergency situation occurs during the school day, or if the pupil becomes ill, school officials are to:

a) Contact me at my office:_____
b) Take child immediately to the emergency room at:_____
c) Other option:_____

Physician's Signature:_____ Date:_____

RELEASE OF LIABILITY FORM

Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. **This form is valid for the term of one year or the annual IEP or 504 Accommodations review, whichever occurs first.**

Parent/Guardian's Signature:_____ Date:_____