Charlotte-Mecklenburg Schools

Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order: Clean Intermittent Catheterization in School Setting

Student's Name: _____ DOB: _____
Student's Address: _____
Student's Phone #: _____ Student's I.D: _____
Mother's Name: _____ Phone: Work _____Cell _____
Father's Name: _____ Phone: Work _____Cell _____
Preferred Hospital: _____
School: _____ Teacher/Grade/Homeroom: _____

Student's Diagnosis: _____

Please have the student's Health Care Provider complete the following information:

1. Catheterize student with catheter type: _____ size # at _____am/pm daily while in school using proper clean technique.
2. Observe for signs and symptoms of urinary tract infection including: dark or cloudy urine, foul/strong smelling urine, blood, discharge, abdominal/flank pain, vomiting.
3. Report signs and symptoms to parent/guardian.
4. If unable to successfully catheterize student, call parent/guardian.
5. Document care daily on procedure flow sheet.
6. Maximum amount of urine to be obtained with each catheterization:
7. Other:
8. Duration of order: School Year _____ :

Health Care Provider _____ Phone # _____FAX #_____
Address:_____
Health Care Provider signature: _____
Date: _____
(Please sign here to authorize this order and return to the School Health Program, MCHD, VCW 3205 Freedom Drive, Suite 8500- Building K Charlotte, N.C. 28208 Fax: 704-432-2079 Attn: School Health.)

I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.
Parent /Guardian Signature_____Date_____

I have provided training and instruction regarding this order to: _____
(Signatures of personnel trained)
_____,_____
_____
School Health Nurse Signature_____ Date_____