

Physician Order for Care of Colostomy, Ileostomy, Urostomy

Name of Student: _____

Birth Date: _____

1. Name of procedure: **Care of Colostomy, Ileostomy, Urostomy**

The parent is required to provide the necessary supplies.

2. Procedure Information:

Frequency of drainage of pouch _____

Times needed at school _____

Bag change at school PRN _____

Solution used for cleaning _____ Other _____

Diapering required _____

Special instructions _____

3. The procedure is to be continued as above until: _____
Date

All authorizations expire at the end of the current school year.

4. This procedure **MUST** be performed by licensed personnel **ONLY**. Yes ___ No ___

Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.

Please specify a person from your facility who can provide training for school personnel.

Name: _____

Phone: _____

Note: RN may need to contact physician in writing or by phone.

Physician's Signature: _____

Date: _____

Print Physician's Name: _____

Phone: _____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child.

Signature of Parent/Guardian

Phone

Date