Houston Independent School District
Health and Medical Services

REQUEST FOR PERFORMANCE OF TREATMENT AT SCHOOL BUILDING DURING SCHOOL HOURS

To the Principal of: _____

Name of Child: _____ Birthdate: _____

Address: _____ Telephone: _____

Email Address: _____

PHYSICIAN

Diagnosis: _____

Etiology: _____

Date of onset: _____

Prognosis: _____

Type of procedures to be performed: _____

_____

How often or at what time? _____

_____

Specific recommendations: _____

_____

_____

Precautions, possible untoward reactions, and interventions: _____

_____

Any other pertinent history or physical findings that may affect this procedure: _____

_____

_____ _____

Date Physician's Signature

_____ _____

Physician's Address Type or Print Physician's Name

_____

Telephone Number

PARENT

I understand that I am giving consent for the school nurse to discuss any concerns regarding this treatment with the healthcare provider whose signature appears on this document.

Should my child manifest any unusual symptoms, please contact _____ at _____ and/or my child's physician immediately.

_____ _____

Parent's Signature Telephone number

_____ _____

Date Alternative Telephone number

Physician's request must be renewed at the beginning of each school year. Any change of treatment must be requested in writing by the physician.

Houston Independent School District
Health and Medical Services

Physician Orders for Respiratory Care

To the Principal of: _____

Child's Name: _____ Date of Birth: _____

Diagnosis: _____ Latex Allergy Present: ☐ Yes ☐ No

Etiology _____ Prognosis _____ Date of Onset _____

Procedures(s) required for the student while in the school setting (check and complete all sections that apply):

☐ Tracheostomy Tube:

Trach Brand: _____ ☐ cuffless ☐ cuffed with _____ cc air or H2O

Trach Size: _____ mm Emergency trach size: _____

If decannulation occurs, how long is this student stable until re-insertion can be completed? _____

If decannulation occurs, re-insert tracheostomy tube: ☐ Yes ☐ No

☐ Suctioning while at school (check all that apply):

☐ Tracheostomy ☐ Nasal Tracheal – Depth: _____

Trach Brand: _____ ☐ cuffless ☐ cuffed with _____ cc air or H2O

Trach Size: _____ mm Use: ☐ Trach Suction Catheter Size: _____ fr ☐ Yankauer

Suction frequency: _____ q hrs or PRN ☐

Suction with saline: PRN (thick secretions) Amount of saline to use: _____ gtts or ml

Passy-muir (speaking) valve use at school: ☐ Yes ☐ No

Cap trach while at school: ☐ Yes ☐ No Frequency: _____

HME (Humidification valve) Thermovent ☐ Yes ☐ No Frequency: _____

☐ Ventilator:

Ventilator at home: ☐ Yes ☐ No ☐ PRN Ventilator at school: ☐ Yes ☐ No ☐ PRN

Amount of time permitted off ventilator: _____

Ventilator Brand: _____

Ventilator Settings:

If SPO2 is less than _____ % or respirations are > _____ bpm or signs of respiratory distress then

Suction, if no improvement connect to the ventilator with the following settings:

Mode: _____ Rate_____ TV_____ iT _____ PS _____ PEEP_____ Low Minute Volume Alarm _____

High Pressure _____ Low Pressure _____ Sensitivity _____

☐ Pulse Oxygen Monitoring: ☐ Continuous ☐ Intermittent ☐ PRN

If Intermitte how often: _____

Treatment parameters for decreased SpO2: _____

☐ Oxygen: _____

Needed at school: ☐ Yes ☐ No ☐ PRN

Needed on the bus: ☐ Yes ☐ No ☐ PRN

Oxygen route: ☐ Trach via mask ☐ trach via T-valve ☐ nasal canula ☐ face mask ☐ vent

Oxygen setting: _____ LPM

Administer O2 if SpO2 < _____ % or the following signs are noted: _____

☐ Nebulizer Treatment at school: ☐ Yes ☐ No ☐ PRN

Delivery route: ☐ face mask ☐ trach mask ☐ trach valve ☐ blowby

Give _____ q _____ hrs x _____ days/ongoing

Special instructions: (Include precautions, possible reactions and interventions) A registered nurse will coordinate the health care of all students, including medications, treatments, and prescribed procedures.

_____

SIGNATURE OF PHYSICIAN TELEPHONE DATE

I request the above procedure(s) be administered to my child as ordered by the physician. I authorize the school nurse to contact my child's physician for information concerning my child when necessary.

SIGNATURE OF PARENT TELEPHONE DATE Rev. 7/11 GJ:slr

Houston Independent School District
Health and Medical Services

Physician Orders for Tube Feedings

To the Principal of: _____School

Child's Name: _____ Date of Birth: _____

Diagnosis: _____ Latex Allergy Present: ☐ Yes ☐ No

Etiology_____Prognosis_____Date of Onset _____

Tube Feeding Route:

☐ Gastrostomy tube ☐ Nasogastric ☐ Orogastric ☐ Nasojejunal
☐ Gastrostomy button ☐ Jejunostomy tube ☐ Nasoduoduodenal

Type of tube feeding:

☐ Bolus method ☐ Gravity
☐ Continuous ☐ Pump – rate _____
☐ Other

Brand of Device: ☐ Mic-Key ☐ Mic G ☐ Mini ☐ Bard ☐ Other: _____
Tube size:_____fr Balloon volume:_____
Formula: _____
Amount of Formula: _____
Schedule of feedings: _____
Flush with_____cc's water before and after the feeding.
How much additional water may be administered each day at school?_____Oz
Precautions, possible untoward reactions and interventions: _____
_____
Amount of food or drink that may be taken by mouth (if any): _____
Hold feeding if residual >_____cc
Vent the G-Tube: Yes ☐ No ☐
Does the student have Fundoplication? ☐ Yes ☐ No

A registered nurse will coordinate the health care of all students, including medications, treatments, and prescribed procedures. Note: If the tube is displaced the nurse will cover the stoma and contact the parent.

_____ _____ _____
Signature of Physician Telephone Date

I request the above procedure(s) be administered to my child as ordered by the physician. I authorize the school nurse to contact my child's physician for information concerning my child when necessary.

_____ _____ _____
Signature of Parent Telephone Date

Houston Independent School District
Health and Medical Services

Policies Governing Administering Medication During School Hours

The policy of the Board of Education does not authorize Houston school personnel to give medication of any kind. That includes aspirin, similar preparation, or any other drugs.

Nurses and other school personnel, however, can give medication during school hours under the following restrictions. Pupils who are noncontagious, on long-term medication, on preventative medication, or for a prolonged period on medication that cannot under any arrangement be administered other than during school hours may take medication in school. The healthcare provider's statement must be accompanied by written permission of at least one parent.

Healthcare Provider's Request for Administration of Medication at School Building During School Hours

To the principal of: _____ School Date: _____

Name of child: _____ Birthdate: _____

Diagnosis: _____ ❑Infections ❑ Non-Infectious

In order to keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.

Name of medication: _____ Color (if applicable): _____

Form of medication:

❑tablet ❑ pill ❑ capsule ❑liquid ❑ inhalation ❑ injection*

❑other (specify):_____

(* Injectable medications may be given at school only when the family physician addresses a written request for this service to Director of Health and Medical Services, giving detailed information concerning the administration of the medication and follow-up. Parents shall be instructed to furnish sterile, disposable syringes and needles which will be returned to the parent for disposal after use.)

Dosage (amount to be given): _____

Frequency: _____

Common side effects: _____

Remarks: _____

This is permission to give medication to my child named above as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document in order to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone:

_____
Date:

_____
Facility Name

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Telephone

HISD | Nutrition Services
WE SOLVE. WE SERVE. WE NOURISH.

Physician's Request for Special Dietary Accommodations

Date: _____

School Year: _____

All sections must be completely filled out for this form to be accepted. *indicates required field.

A. THIS SECTION TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

***Student Last Name:** _____ ***First Name:** _____ **Date of Birth:** ___/___/___

School: _____ **Grade:** _____ **Student ID:** _____

Parent/Guardian Name: _____ **Phone:** _____

School Nurse: _____ **Phone:** _____

I give Health Services/Nutrition Services permission to speak with the below named Physician or Authorized Medical Authority to discuss the dietary needs described below.

Parent Signature: _____ **Date:** _____

B. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

***Does the child have a disability and/or anaphylactic/life-threatening food allergy?** ☐ YES ☐ NO *If YES selected, form must be completed and signed by licensed physician.*

***If YES, please describe the major life activities affected by the disability:** _____

***MEDICAL DIAGNOSIS:** _____

ACCOMMODATIONS NEEDED

^Soy milk is the standard substitution when Fluid Dairy Milk is omitted

I. Restrictions Needed: ☐ **NONE**

☐ No Fluid Dairy Milk^ ☐ No Dairy Products (yogurt, cheese, etc) ☐ No Milk Protein/Milk Ingredients (in baked goods, etc.)

☐ No Whole Eggs ☐ No Eggs as an ingredient

☐ No Wheat/Gluten ☐ No Soy ingredients

☐ No Peanuts ☐ No Tree Nuts *(please note that HISD does not serve peanuts or tree nuts on the regular menus)*

☐ No foods processed in a facility that contains nuts

☐ No Seafood

☐ Other (Please list) _____

Substitutions _____

II. Texture Modification: ☐ **NONE**

Duration: *(choose one)*

☐ Year-Round

☐ Temporary: Start _____ Stop _____

Liquids: *(choose one)*

☐ Mildly Thick (Level 2)

☐ Moderately Thick (Level 3)

☐ Extremely Thick (Level 4)

Solids: *(choose one)*

☐ Soft & Bite-Sized (Level 6)

☐ Minced & Moist (Level 5)

☐ Pureed (Level 4)

III. Supplement: ☐ **NONE**

☐ NPO ☐ Supplement to accompany oral diet

☐ Boost Kid Essentials 1.5 ☐ Pediasure ☐ Pediasure with Fiber ☐ Pediasure with Fiber 1.5 ☐ Pediasure Enteral with Fiber 1.0

☐ Other: _____ **Supplements not listed above may take up to 6 weeks to be processed.*

Dosage Per Meal **(REQUIRED)**: ____Breakfast ____Lunch ____After School Snack

IV. Therapeutic Diet Order: Please provide specifics as needed. _____

_____

C. THIS SECTION TO BE COMPLETED BY LICENSED PHYSICIAN / PRESCRIBING MEDICAL AUTHORITY

I certify that the above named student needs special dietary accommodations, as described above, because of the student's disability and/ or life-threatening food allergy or food intolerance/allergy, as indicated.

_____ ☐MD ☐DO ☐NP ☐PA

***Signature of Licensed Physician/Prescribing Medical Authority** Date

_____

***Printed Name of Licensed Physician/Prescribing Medical Authority**

_____

Phone Fax

_____

Address

Send completed form to school nurse. *Please submit new Physician Request form each school year. Any change or discontinuation must be submitted in writing by the physician. Please allow two business weeks for processing. Fax completed forms to (713) 491-5998. Contact NSSPECIALDIETS@houstonisd.org with questions.*