# REQUEST FOR PERFORMANCE OF TREATMENT AT SCHOOL BUILDING DURING SCHOOL HOURS

<table>
<thead>
<tr>
<th>To the Principal of:</th>
<th>Birthdate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Child:</td>
<td>Telephone:</td>
</tr>
<tr>
<td>Address:</td>
<td>Email Address:</td>
</tr>
</tbody>
</table>

| 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: |

<table>
<thead>
<tr>
<th>Date</th>
<th>Physician’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Address</td>
<td>Type or Print Physician’s Name</td>
</tr>
<tr>
<td>Telephone Number</td>
<td></td>
</tr>
</tbody>
</table>

**Physician**

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.

<table>
<thead>
<tr>
<th>Parent’s Signature</th>
<th>Telephone number</th>
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<tbody>
<tr>
<td>Date</td>
<td>Alternative Telephone number</td>
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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.

Rev.: 7/13/2010
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: ________________________ mm Emergency trach size: __________
  Trach Size: __________ mm Cuffless Cuffed with ________ cc air or H2O
  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: ________________________ mm 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 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
  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 Intermittent 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:s lr
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 □ Orogastic □ Nasojejunal
□ Gastrostomy button □ Jejunostomy tube □ Nasoduododenal

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

Rev. 6/20
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

Parent’s Telephone: __________________________
Date: __________________________

Facility Name

Physician’s/Advanced Practice Nurse Signature

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

Telephone
Physician’s Request for Special Dietary Accommodations

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, please describe the major life activities affected by the disability:

*MEDICAL DIAGNOSIS:

ACCOMMODATIONS NEEDED

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

*Restrictions listed above may take up to 6 weeks to be processed.

Duration: (choose one)

☐ Year-Round  ☐ Temporarily: Start ______ Stop ______

Liquids: (choose one)

☐ Mildly Thick (Level 2)  ☐ Soft & Bitesized (Level 6)

☐ Moderately Thick (Level 3)  ☐ Minced & Moist (Level 5)

☐ Extremely Thick (Level 4)  ☐ 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: ____________________________________________________________________________

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 NISSPECIALDIETS@houstonisd.org with questions.