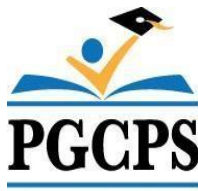


Prince George's County Public Schools
 Prescriber's Order Form for
Specialized Treatments Order Form

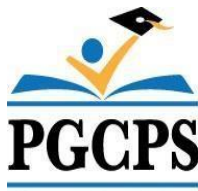
This order is valid **ONLY** for the school year (current) _____ including the ESY/summer session.

PART 1: PARENT/LEGAL GUARDIAN TO COMPLETE			
Student's name:		Birthdate:	
School:		Grade:	
Parent/Guardian Name (print):			
Home phone #:	Cell phone #:	Work phone #:	
Known Allergies: <input type="checkbox"/> None	<input type="checkbox"/> Specify:		
<ul style="list-style-type: none"> I hereby authorize the procedure/treatment described below to be performed as directed by my child's health care prescriber. I understand that the prescriber will be called if a question arises about my child's procedure/treatment as allowed by HIPAA. I understand that I must supply the school with the equipment/supplies needed to perform procedure/treatment. I understand that at the end of the school year, an adult must pick up the equipment/supplies, otherwise it will be discarded. 			
Parent/Guardian Signature:		Date:	
PART 2: LICENSED PRESCRIBER TO COMPLETE			
Medical Condition(s):			
Treatment/procedure start date (month/day/year):		Treatment/procedure end date (month/day/year):	
<input type="checkbox"/> CLEAN INTERMITTENT CATHETERIZATION AT SCHOOL (CIC)			
Catheter size:	Frequency:	Time(s):	
Special Instructions:			
<input type="checkbox"/> OSTOMY			
Pouch/bag type:		Pouch/bag size:	
Special skin precaution procedure:			
<input type="checkbox"/> SUCTIONING			
Type: <input type="checkbox"/> Nasal <input type="checkbox"/> Oral <input type="checkbox"/> Tracheal	Catheter size:	Suction Depth:	Suctioning time(s):
Tracheostomy Type:	Cuffed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Trach size: Back-up size:	
Ventilator: <input type="checkbox"/> Yes <input type="checkbox"/> No	CPAP: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ventilator Type:	CPAP Settings:		
Ventilator Settings:			
Oxygen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Oxygen Settings:	Delivery Method: <input type="checkbox"/> NC <input type="checkbox"/> FM <input type="checkbox"/> TM	
Diaphragmatic pacer: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Special Instructions:			
<input type="checkbox"/> TUBE FEEDING			
Feeding tube type: <input type="checkbox"/> Nasogastric <input type="checkbox"/> Gastrostomy <input type="checkbox"/> Gastro-Jejunum <input type="checkbox"/> Other:			Tube size:



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Formula type:		Formula amount to be delivered:	
Formula may be substituted as needed with:			
Delivery method: <input type="checkbox"/> Pump <input type="checkbox"/> Gravity		Pump type:	
Time(s):	Rate of delivery:	Flush amount:	
May replace tube: <input type="checkbox"/> Yes <input type="checkbox"/> No	Size of replacement tube:	Balloon fill _____ cc/ml	
Special Instructions: <ol style="list-style-type: none"> 1. Feeding will run a minimum of 20-30 minutes. Students will be in a sitting position, unless otherwise instructed. 2. In the event of abdominal distention, gagging or emesis, feeding will be discontinued and parents contacted for further instructions. Carbonated beverages may be used to flush tubing in case of clogging. Decompression may be used to vent the button. 3. In the event the GT Mic-KeY /MiniOne Button gets dislodged, the school nurse may re-insert the same size GT Mic-Key or MiniOne student is currently using. <u>If unable to re-insert GT cover site with dry gauze and contact the parent immediately.</u> 4. Other: <p style="text-align: center; margin-top: 20px;">*Note: G/J, J-Tubes and PEG Tubes are <u>inserted by a physician only</u> and cannot be changed by a nurse.</p>			
<input type="checkbox"/> VAGUS NERVE STIMULATOR (VNS)			
*PLEASE NOTE: 911 will be called immediately for: <ol style="list-style-type: none"> 1. Seizure lasting longer than 5 minutes 2. Repeated seizures occurring one after another 3. Difficulty breathing occurring with any seizure 			
Magnet to be used with VNS: <input type="checkbox"/> Immediately after start of seizure <input type="checkbox"/> Seizure lasting greater than _____ minutes			
If seizure still ongoing after initial use, may repeat magnet swipe over VNS in: <input type="checkbox"/> _____ Seconds <input type="checkbox"/> _____ Minutes			
Special Instructions:			
<input type="checkbox"/> WOUND CARE			
Type of Wound:	Type of dressing:	Dressing change time(s):	
Dressing procedure/instructions:			
<input type="checkbox"/> OTHER MEDICAL DEVICES			
<input type="checkbox"/> Ankle Foot Orthosis (AFOs) <input type="checkbox"/> Braces <input type="checkbox"/> Scoliosis brace <input type="checkbox"/> Slings <input type="checkbox"/> Splints <input type="checkbox"/> Other:			
Special Instructions:			
Prescriber's Name/Title (printed):		NPI#	
Prescriber's office phone #:		Prescriber's office fax #:	
Prescriber's office address:			
Prescriber's Signature: (Original Signature or signature stamp only)		Date:	
Order reviewed by RN/LPN:		Date:	



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Plan of Care for School Attendance

Medications needed during the school day (scheduled and PRN): YES NO (if yes, a prescriber order form needed for each)

DME and Supplies:

Safety Measures:

Functional Limitations:

- Amputation Paralysis
- Legally Blind Bowel/Bladder (incontinence)
- Endurance Contracture
- Ambulation Depressed
- Hearing Speech
- Agitated Dyspnea w/minimal extortion
- Other (specify):

Activities Permitted:

- Up as Tolerated Wheelchair
- Transfer Bed/Chair Walker
- Exercise prescribed No restrictions
- Partial weight bearing
- Crutches
- Cane
- Other (specify):

Mental Status:

- Oriented Comatosed Forgetful Depressed
- Disoriented Lethargic Agitated Other (specify):

Prognosis: Poor Guarded Fair Good Excellent Other (specify):

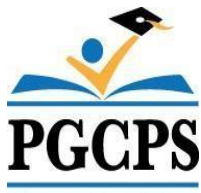
Orders for Discipline and Treatments (specify amount/frequency/duration) not identified in medication or specialized procedures and treatments orders required during the school day:

Physician's Name, Address and Phone number:

NPI:

I certify that this patient requires skilled nursing services while attending school. This patient is under my care and I have authorized the services on this plan and will periodically review and update as needed.

Attending Physician's Signature and Date Signed:



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