GREENVILLE COUNTY SCHOOLS
Inspire | Support | Prepare

GCS Health Services Medical Procedure Authorization Form

Student Name: ______________________ **Date of Birth:** ______________________
Medical Diagnosis (es): ______________________ **Allergies:** ______________________

AIRWAY

Start Date: ______________________ End Date: ______________________
Suctioning: ☐ Nasal ☐ Nasopharyngeal ☐ Oral ☐ Tracheal
Frequency: ____________ Size of Catheter: ____________ Length/Insertion depth(cm): ____________
Other respiratory procedure/frequency: ______________________
Tracheostomy Type and size: ______________________ ☐ Uncuffed ☐ Cuffed(water/air: ______ml)
Oxygen: ______________________ ☐ Face Mask ☐ Nasal Cannula ☐ Other
CPAP: ______________________
Additional Instructions: ______________________
____
Pulse Oximetry: ☐ Continuous ☐ Intermittent Checks: ______________________

NUTRITION

Start Date: ______________________ End Date: ______________________
Type of Tube: ☐ Nasogastric(NG) ☐ Gastrostomy(GT) ☐ Combo(Jejunostomy/Gastrostomy (GJ)
FR Size/Length: ____________ Balloon Volume: ____________
Formula: ______________________ ☐ Continuous ☐ Bolus
Volume: ______________________ ☐ By Gravity ☐ By Pump
Rate: ______________________(ml/hr)
Scheduled Time(s): ______________________ Pump Type: ______________________
Water flush/Amount: ☐ After feeds: __________ (ml)
☐ Scheduled: __________ (ml) Time(s): ______________________

ELIMINATION

Start Date: ______________________ End Date: ______________________
Continuous Indwelling Catheter (CIC): Size: ______________
Frequency/Time: ______________________
Intermittent Catheterization: ______________ Size: ______________
Frequency/Time: ______________________
Student may perform catheterization: ☐ Without nursing supervision* ☐ Requires nursing supervision
*If student will perform self-catherization independently, licensed healthcare provider and parent must also complete MED-2 Self-Administer Authorization Form
Other: ______________________

Additional Procedures: ☐ Blood Pressure Check ☐ Blood Glucose Check ☐ Other: ______________
Start Date: ______________ End Date:______________ Time of day: ______________
Additional Information: ______________________

Printed Name of Licensed Health Care Provider Office Address:	Phone: Fax:
Signature of Licensed Health Care Provider (Required):	Date:

Parent/ Legal Guardian please read carefully:

- I will notify the school when the procedure is discontinued or there are changes
- I give permission for the principal, school nurse(s), and/or health services to share this information with individuals who have responsibility for my child
- I give GCS Health Services my permission to contact the above named Licensed Health Care Provider
- I am responsible for replacing supplies as requested
- I give my permission for designated GCS staff to provide care to my child according to district requirements

Parent/Legal Guardian's Signature (Required):______________________Date: ____________

Parent/Legal Guardian's Printed Name: ______________________ Phone: ______________