

# GENOA CENTRAL SCHOOL DISTRICT

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**Student Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**School** \_\_\_\_\_

**Grade** \_\_\_\_\_

This patient has a condition that he/she is unable to void on his/her own. During school hours Clean Intermittent Catheterization is prescribed:

Cath via site \_\_\_\_\_

Catheter size \_\_\_\_\_

Catheter every \_\_\_\_\_ hours or \_\_\_\_\_ times per day

Irrigate bladder with \_\_\_\_\_ to remove mucous plug.

- 8 oz. glass of water with every catheterization.
- The student is capable and has been instructed on performing self-catheterization.
- The student is not approved to perform self-catheterization

Other instructions:

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## Precautions:

Contact the parent if the followings signs are noted. These symptoms may indicate a urinary tract infection:

- Cloudy urine
- Blood in the urine
- Foul smelling urine
- Fever of 100 or above.

It is also important to note that force should never be used to insert the catheter. If force is needed to insert the catheter, do not continue the procedure. The parent should be notified immediately.

## Note:

Adjustment in the treatment or discontinuation of the treatment requires a written, signed physician's order. Order must be renewed each school year.

All equipment and supplies needed for the CIC will be provided by the parent.

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

## HOME OF THE MIGHTY DRAGONS!

**Kristi Wooten, RN**  
Elementary School Nurse  
Phone: 870-653-7508

**Rachel Hoover, RN**  
Middle School Nurse  
Phone: 870-653-7594

**Amanda Green, RN**  
High School Nurse  
Phone: 870-653-7532

# GENOA CENTRAL SCHOOL DISTRICT

## Parent/Guardian Consent for Unlicensed Assistive Personnel to Perform CIC

I  do /  do not (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer medication or perform CIC to my child while in attendance at Genoa School District or Genoa School District related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein.

Parent initials \_\_\_\_\_

## Parent/Guardian Consent to Share Information and Picture

I  do /  do not (check one) authorize Genoa School District to display a picture of my child (if applicable) and identify that this is a person with \_\_\_\_\_. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year.

Parent initials \_\_\_\_\_

## Parent/Guardian Authorization for School Staff to Communicate Health Information

*I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other GCSO form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described in this agreement shall not be provided to a student without the required consent of the parent/guardian, as outlined herein.*

Parent initials \_\_\_\_\_

## Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the Administration of Medication to the student, Treatment/Procedure and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's Administration of Medication and/or Treatment/Procedure described in this document to the student and/or the disclosure of Individually Identifiable Health Information,, including but not limited to claims that School Staff negligently failed to recognize symptoms requiring the use of my child's Medication/Treatment/Procedure, misconstrued symptoms which it believed necessitated the use of my child's Medication/Treatment/Procedure, negligently administered or failed to administer Medication(s), Treatment/Procedure and/or "over-disclosed" my child's Individually Identifiable Health Information.

Parent/Guardian Name \_\_\_\_\_

Phone \_\_\_\_\_

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