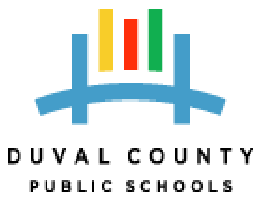

DUVAL COUNTY PUBLIC SCHOOLS
FLORIDA DEPARTMENT OF HEALTH – DUVAL COUNTY
SCHOOL HEALTH SERVICES

PROCEDURE PHYSICIAN ORDER FORM

(MUST BE FILLED OUT COMPLETELY BY PHYSICIAN)

Name ________________________________DOB ___________Grade ______Teacher ______________

ICD10 Code ______________ Diagnosis ____

School Year ______________ Allergies ____

☐ **CATHETERIZATION**: Type ______________________ Size ______Time(s) of Procedure ____________

☐ **OSTOMY**: Type ______________________________ ☐ Ostomy Care, Frequency __________________

☐ **FEEDING**: Type ☐ G-Tube ☐ J-Tube ☐ PEG ☐ Button ☐ Other ________________ Size ______________

☐ Tube Site Care, Frequency ____________ Tube Feeding Method: ☐ Bolus by gravity ☐ Bag ☐ Syringe

☐ Mechanical Pump – Type of Pump ____________________________ Rate of Flow __________ cc/hr

Formula ______________________ Amount ______________ Time of Feeding(s) ___________________

Volume of Water to Follow Feeding _____cc Check Residual: ☐ Yes ☐ No Hold feeding for residual > ____cc

☐ RN/LPN to replace G-tube if displaced during school hours and notify parent (parent to supply replacement)

☐ **SUCTIONING**: ☐ Nasal ☐ Oral ☐ Tracheostomy Frequency _____________________________________

☐ **TRACHEOSTOMY**: Type __________________________________ Size ___________ Cuffed: ☐ Yes ☐ No

☐ Emergency Trach Tube Replacement ☐ Trach Skin Care, Frequency ____________________________

☐ **PULSE OXIMETRY** Frequency ______________________________ Maintain O2 Sats above ________ %

Call 911 if O2 Sats remains below _______ % for ______ minutes.

☐ **OXYGEN ADMINISTRATION**: ☐ Mask ☐ Nasal Cannula ☐ Other, describe __________________________

Administer ____ Liters of Oxygen for O2 Sats below ____ %. Continue Oxygen for ____ minutes or until O2

Sats rise above ____ %. Call 911 if O2 Sats remain below ____ % for ____ minutes.

☐ **OTHER**: ____

PRECAUTIONS/SPECIAL INSTRUCTIONS: ____

VENTILATOR: This requires consultation with the School Health Services Department - Please call (904) 348-7876

____/____/____ ________________________________ ______________ ________________

Date | Physician Signature | Phone Number | Office Stamp

Parent/Legal Guardian Permission

I hereby request and give permission for my child to be given the above prescribed treatment/procedure while in school. I will notify the school immediately if the health status of my child changes, we change physicians, or if there is a change in treatment/procedure. I understand that if there is special equipment or supplies needed to perform this treatment/procedure, it will be maintained by me, delivered to the school in good working condition, and school personnel will assume no responsibility for the maintenance and/or delivery of special equipment/supplies. I authorize my child's school nurse or district medical personnel to assess my child in regards to his/her special health care needs. I authorize my child's school nurse or district medical personnel to discuss my child with the physician or physician's office as needed throughout the school year.

Parent/Guardian Name ____ Date ________________

Parent/Guardian Signature _____________________________________Phone Number _____________