Holly Area Schools

Urinary Catheterization Care Plan

*****This care plan is valid for one calendar school year and must be updated by physician if any changes are made to the students treatment*

Student's Name: _____ School Year: _____

Date of Birth: _____ School/Program:_____

Age: _____ Grade: _____ Teacher: _____

First Contact	**Second Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____

I agree with this plan as written and for school staff to share this information with those that need to know. I agree for staff to contact the treating healthcare professional for clarification of this plan, if needed. This form is valid for one school calendar year and needs to be updated by a licensed medical provider if changes occur.

☐ YES ☐ NO I have read the attached information regarding section 504 eligibility
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation

Parent/Guardian Name_____
Signature: _____ **Date:** _____

To be completed by the Physician:

☐ **Urinary Catheterization:**

Catheter size: _____ Brand: _____
Frequency: _____ Catheter insertion location: _____
Time of day/Indication: _____ ☐ May be repeated, if needed.

☐ **Foley Care: (Please list directions)**

_____
_____

☐ **Other**: _____
_____

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____