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 certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of treatment/ care or medications at school. I agree with this plan as written and for school staff to share this information with those that need to know. I agree for HAS staff to contact the treating healthcare professional for clarification of this plan, if needed. I will not hold the Board of Education, its personnel, or employees responsible for complications related to treatment/care administered pursuant to this plan.

Parent/Guardian Name_____

Signature: _____ **Date:** _____

To be completed by the Physician:

☐ **Urinary Catheterization:**

Catheter size: _____ Brand: _____

Frequency: _____ Catheter insertion location: Urethra

Time of day/Indication: _____ ☐ May be repeated, if needed.

☐ Only need to change pull up or brief if solid.

☐ Change pull up/brief with every catheterization even it it is not solid.

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

_____

_____

☐ **Other**: _____

Physician/Licensed Prescriber Name (Print): _____

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

Signature: _____ **Date:** _____

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

5/2024 **Office Use:** Skyward Alert: ___ Email: ___ Date: _____ Initials: _____