HEALTH SERVICES

PHYSICIAN'S ORDERS FOR COLOSTOMY/ILEOSTOMY CARE

School year 20___ - 20___

Student _____ School _____ Teacher _____

Diagnosis _____ Date _____

Care to be done by:
_____ Licensed Personnel
_____ Student with assistance

Procedure:
_____ Frequency/specific times

_____

_____ Indications for Use/Symptoms

_____

_____

_____

_____ Additional orders/recommendations for care of student while at school

_____

_____

_____

Physician's signature _____ Date _____

Physician's address _____

Physician's phone number _____ Fax _____

PARENT/GUARDIAN PERMISSION /AUTHORIZATION FOR RELEASE OF INFORMATION
****Parents are required to provide all necessary equipment to the school nurse prior to the procedure being performed.****

I agree to the release/obtaining of medical information to/from Clarksville/Montgomery County School System. Information will be used to develop an Individual Health Care Plan, as well as to facilitate continuity of treatment for the student. All information obtained will remain confidential. This release is valid for one school year and that school year is listed above.

Parent/Guardian signature _____ Date _____

Witness signature _____ Date _____