Physician Order for
Care of Colostomy, Ileostomy, Urostomy

Name of Student:_____ Birth Date:_____

1. Name of procedure: **Care of Colostomy, Ileostomy, Urostomy**

   The parent is required to provide the necessary supplies.

2. Procedure Information:

   Frequency of drainage of pouch_____

   Times needed at school_____

   Bag change at school PRN_____

   Solution used for cleaning _____Other_____

   Diapering required_____

   Special instructions_____

   _____

3. The procedure is to be continued as above until:_____.
   Date

All authorizations expire at the end of the current school year.

4. This procedure MUST be performed by licensed personnel ONLY. Yes___No___
   Be advised that RN's are not in the building every day and some of the procedures are done by trained unlicensed personnel.
   Please specify a person from your facility who can provide training for school personnel.

Name:_____ Phone:_____
Note: RN may need to contact physician in writing or by phone.

Physician's Signature:_____ Date:_____

Print Physician's Name:_____ Phone:_____

Parent permission: I hereby request that the treatment specified above be performed to the above-name child.

_____ _____ _____
Signature of Parent/Guardian Phone Date