Anchorage School District

URINARY CATHETER CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

Catheter Type

☐ Indwelling urethral catheter ☐ Indwelling suprapubic catheter ☐ Intermittent catheter ☐ Condom catheter

MEDICAL PROVIDER AUTHORIZATION

☐ **Provide catheter site care, including perineal cleansing, as needed.**

☐ **Monitor and record urinary output.**

☐ **Complete intermittent urethral catheterization.**

Time(s) to complete catheterization: _____

Catheter type: _____ Catheter size: _____

Other: _____

☐ **Replace indwelling catheter if it becomes obstructed, is leaking, or dislodged.**

Catheter type: _____ Catheter size: _____

Balloon size: _____ Catheter securement device: _____

☐ **Other nursing orders**:

LICENSED MEDICAL PROVIDER IN ALASKA (PRINTED)	TELEPHONE NUMBER
LICENSED MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

PARENT / GUARDIAN AUTHORIZATION

I request that the urinary care outlined on this plan be given to my child. **I will provide needed medications or supplies for care in school.**

Employees and agents of the Anchorage School District ("ASD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless ASD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I will notify ASD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and ASD as part of the provision of my child's care. I agree for the nurse to share health information with ASD staff on a need-to-know basis for my child's safety and to foster academic success.

I understand that ANY remaining urinary care supplies will be disposed of at the end of the school year, unless I pick up the remaining supplies by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

NURSE PLAN REVIEW

I have reviewed the *Urinary Catheter Care Plan* for accuracy and ensure that all required fields and signatures are completed before providing care to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE