Must be completed by a
Licensed Health Professional

Spencer County Public Schools Health Services

INDIVIDUAL HEALTH CARE PLAN

Urinary Catheterization

PRINT Student Name: ______________________ School Year______________
Date of Birth: ______________________ Teacher/Grade______________
Date of Diagnosis: ______________________ Bus Route # ______________

Emergency Contacts:

Name: ______________________ Numbers: ______________________
Name: ______________________ Numbers: ______________________
Name: ______________________ Numbers: ______________________

PRINT Treating Physician Name:______________________ Number: ______________
Physician Address: ______________________FAX # ______________

MEDICAL DIAGNOSIS: ______________________________________

Urinary Catheterization: ☐ Urethral ☐ Suprapubic

Times Catheterization is needed:

__________ __________ __________

Can this student catheterize him or herself?
Yes ____ Independently ____ Adult Assistance ____ No ____

Supplies Provided to School by Parent/Guardian: ______________________________________
____

Circle the typical characteristics of student's urine: Clear Cloudy Odor Typically has blood in

Typical color : __________ Typical amount of output: __________

Please list all medication(s) / medical device(s) prescribed for home and/or school:

____

____

***NOTE: Parent and Physician must complete a Permission for Prescribed or Over-the the Counter Medication Form for each medication needed at school.**

Call parent/guardian if the following are observed:

____
____

Additional instructions/comments:

____

PHYSICIAN/MEDICAL Signature ______________________________ Date ______________

PARENT Signature ______________________________ Date ______________

STAFF/SCHOOL NURSE Signature ______________________________ Date______________