

**Antelope Valley Union High School District
Colostomy Orders**

***** PHYSICIAN SECTION *****		
The Authorized Health Care Provider (signing below) must be licensed within the State of California to prescribe medication. (California Education Code 49423 and 49423.6)		
Student Name	DOB	Date Authorized
Parent / Guardian Name		Work / Cell Phone
Parent / Guardian Name		Work / Cell Phone
Ostomy bag brand / type		Size
Times to check bag _____ a.m. _____ p.m. _____ prn		Skin Barrier Preference
If this procedure is required during school hours, these orders will be in effect until July 31 st of the summer following the school year for which they are prescribed.		
Name of Authorized Health Care Provider		Signature
Address		Phone
***** PARENT SECTION *****		
Initials required # 1,2 and 3 a or b		
<p>1. I give my permission as the parent or legal guardian of the above named student to initiate this request for colostomy care for my child. I acknowledge that my child may be assisted to perform colostomy care to himself / herself by a school employee trained by the District Nurse. Ostomy supplies that do not have matching information on the written statement and their container, or are not in their original containers, will not be accepted or administered. Supplies will be counted upon receipt in the health office. All equipment / supplies are the responsibility of the parent. _____ initials</p>		
<p>2. In order for this colostomy care to be available to my child at school, I give my permission for the credentialed school nurse to communicate directly with the student's physician, as may be necessary, regarding the physician's written statement or any other questions that may arise with regard to specialized colostomy procedures. I may terminate my consent for administration of this procedure at school at any time. _____ initials</p>		
<p>3a. My child has been trained to carry and provide self-care and is both responsible and capable of performing this procedure, without assistance or supervision, at school. He / She is also capable and responsible to transport this medication to and from school. I release the district and school personnel from civil liability if my child suffers from an adverse reaction as a result of self-administering this procedure. _____ initials</p>		
<p>or 3b. I request that my child be assisted and supervised during administration of the colostomy procedure at school and not be permitted to administer or carry this medication without proper supervision from school personnel. _____ initials</p>		
Signature of Parent / Legal Guardian		Date

Revised 2008