SAN ANTONIO INDEPENDENT SCHOOL DISTRICT
STUDENT HEALTH SERVICES DEPARTMENT
STUDENTS WITH SPECIAL PROCEDURES / SPECIAL NEEDS

SCHOOL NAME: _____ **20 _____ - 20 _____** **NURSE:** _____
Please indicate time for each procedure.

STUDENT NAME	I◇	C●	T♥	GRADE	DX.	PROCEDURE/ TIME(S)	PROCEDURE/ TIME(S)
						G-tube feed/_____ Meds. per G-Tube/_____ Replace G-Tube/PRN (circle)	Nebulizer/_____
						CIC*/_____	Oral Suct./_____ Trach Suct/_____
						Insulin Adm./_____ B.G.**/_____ Ketone check/PRN(circle) Glucagon/PRN (circle)	Ileostomy Care/_____ Colostomy Care/_____ Oxygen/PRN/Continuous (circle) Transfer per Hoyer_____
						Epi-Pen/Twin-Ject PRN (circle) Agency Nurse:_____ **(Name of Agency)**	Other:_____/_____ Other:_____/_____
STUDENT NAME	**I◇**	**C●**	**T♥**	**GRADE**	**DX.**	**PROCEDURE/ TIME(S)**	**PROCEDURE/ TIME(S)**
						G-tube feed/_____ Meds. per G-Tube/_____ Replace G-Tube/PRN (circle)	Nebulizer/_____
						CIC*/_____	Oral Suction./_____ Trach.Suction/_____
						Insulin Adm./_____ B.G.**/_____ Ketone check/_____ Glucagon/PRN (circle)	Ileostomy Care/_____ Colostomy Care/_____ Oxygen/ PRN/Continuous (circle) Transfer per Hoyer_____
						Epi-Pen/PRN (circle) Agency Nurse:_____ **(Name of Agency)**	Other:_____/_____ Other:_____/_____

SEND TO YOUR NURSING COORDINATOR AT STUDENT HEALTH SERVICES BY THE END OF THE 1ST WEEK OF SCHOOL. SCHOOLS WITH NO SPECIAL PROCEDURES MARK *NONE* ACROSS SHEET. AS STUDENTS WITH SPECIAL PROCEDURES/SPECIAL NEEDS ENTER, WITHDRAW OR TRANSFER , SUBMIT CHANGES TO YOUR NURSING COORDINATOR.

(**I◇**Initial Order for student; **C●** Change in order, etc.; **T♥** Student Transfer; * **CIC** Clean Intermittent Catheterization; ** **BG** Blood Glucose Check)