Clear Form

PHYSICIAN'S REFERRAL FOR IN-SCHOOL NURSING SERVICES

This form is to be completed by the physician when specific nurse expertise is needed to administer medications and/or treatments to students within the school day. A review of this referral will be conducted by the IEP/504 team for determination of supports and services.

SECTION I
(to be completed by the school or ESE Office)

Student: _____ ( )M ( )F DOB: _____

I.D.#: _____ Medicaid #: _____

Name of Parent/Guardian: _____ Telephone: _____

Address (include city and zip code): _____

Emergency Contact/Telephone (if different from above): _____

Current School: _____ School Hours: _____

School/ESE Office Contact Person/Telephone: _____

SECTION II: TO THE PHYSICIAN
(to be completed by the physician)

Miami-Dade County Public Schools (M-DCPS) provides nursing services during school hours when these services are required to allow the student to attend a school-based program and if services are needed for the student to access an educational program.

( ) Initial Orders ( ) Annual Update ( ) Changed Orders ( ) Discontinuation

Note: A new form for in-school nursing services must be completed and signed annually or at any time that new orders are issued or current orders have changed, for example, as a result of a hospitalization or surgical procedure.

SECTION III
(to be completed by the physician)

Diagnosis (1): _____ Medicaid Diagnostic Code (1): _____

Allergies: _____

Precautions (include history of drug reactions): _____

SECTION IV: NURSING ORDERS - DIABETES TREATMENT
(to be completed by the physician)

Parent/guardian will be responsible for providing all equipment, supplies, and medications.

Attach the Diabetes/Medication Treatment Plan or complete the information below.

Student has been trained by healthcare professional: ☐ Yes ☐ No

Blood glucose (BG) testing:

Target range for BG: _____ Type of Meter: _____

☐ Before lunch ☐ Anytime student does not feel well

☐ ____ hours after meals ☐ Other: _____

☐ Before/after exercise _____

Insulin Delivery: ☐ Syringe/Vial ☐ Pen ☐ Pump

Calculate insulin dose for carbohydrate intake: ☐ Yes ☐ No

Carbohydrate Coverage: _____ # unit(s) of insulin per _____ grams of carbohydrate.

☐ Add carbohydrate dose to correction dose at lunch.

Insulin Sliding Scale	
BLOOD SUGAR	**DOSE**
-	
-	
-	
-	
-	
-	

SECTION V: NURSING ORDERS - MEDICATIONS AND TREATMENTS
(to be completed by the physician)
Parent/guardian will be responsible for providing all equipment, supplies, and medications.

MEDICATION	Route	Dose	Time of Day *(within school day)*	Special Instructions

TREATMENT	Description	Time of Day *(within school day)*	Special Instructions
Catheterization			
G-Tube Feeding			
Tracheotomy Care			
Respiratory Treatments			
Seizure Precautions			
Other (specify):			

SECTION VI: PHYSICIAN'S CERTIFICATION
(to be completed by the physician)

I certify that the nursing services listed in sections II-V are recommended in order for the student to attend a school-based program and that these services are needed to access an educational program. I understand that for further clarification of these orders, I may be contacted by Miami-Dade County Public Schools staff, Medical Consultant, or the contracted nursing agency.

Physician's Signature _____ Date _____

Physician's Name (please print) _____ Telephone Number _____

Address/City/State/Zip Code _____

Student's Name: _____ School: _____

Parents should return this form to the school principal/designee.