Nursing Support Services

Delegated Care in the School Setting – Order Form

NSS provides care in the school setting for children (5 – 19 years) who require assistance with specific medical tasks related to their care. It is important to note that delegation is only available for certain tasks (see below) and the decision regarding whether a task can be safely delegated rests with the registered nurse, who carefully considers several factors including: the school environment in which the task will be performed, the complexity of the task itself, the potential risk of harm to the student, the predictability task's outcome, and the school staff's ability to consistently and safely perform out the task. This thorough assessment and determination help to ensure that the well-being and safety of the students remain our utmost priority.

Nursing Support Services (NSS) Care in the School Setting ORDER FORM: Prescriber to Complete

Instructions for Prescriber:

- *Please complete this form as it provides the child-specific orders a nurse requires to establish a delegated care plan for the child/youth.*
- *Care plans will be enacted by school support staff (non-medical professional) while the **child/youth is attending school.***
- *School care must be **routine, essential (cannot be given outside school hours)**, and have a **predictable** response.*
- *For delegated care in the school setting, orders must be updated annually and/or when changes occur in child's medical care needs.*
- *Once a child is on service, **any order changes** need to be given to the NSS Coordinator directly for the delegated care plan to be updated and for school staff to provide care accordingly*

NAME OF CHILD	BIRTH DATE (YYYY/MM/DD)

CONDITION(S) REQUIRING MEDICATION:

Child requires G/GJ/J tube meals at school: Please fill in tube meal details below or if RD to write order, please indicate below

☐ **Pump Feed** Tube type: ☐ G ☐ GJ ☐ J

Bolus feeds: ☐ formula[1]: _____ Total Volume: _____ml Rate: _____ ml/hr Feeding time(s) at school: _____

☐ water Total Volume: _____ml Rate: _____ ml/hr Admin time(s) at school: _____

Continuous Feeds: ☐ formula: _____ Total Volume: _____ml (per day) Rate: _____ ml/hr

Flushes: ☐ timing of flush (i.e. before aftermeds and feeds) _____ Volume ☐ _____ ml

☐ **Syringe Feed** Tube type: ☐ G ☐ GJ ☐ J

☐ formula[1]: _____ Total Volume: ____ml Rate: _____ (__ ml per syringe over ___minutes) Feeding time(s) at school: _____

☐ water Total Volume: _____ml Rate: _____ (__ ml per syringe over ___minutes) Admin time(s) at school: _____

Flushes: ☐ timing of flush (i.e. before aftermeds and feeds) _____ Volume ☐ _____ ml

☐ If ordering **Home Blenderized Tube Feeds**[1] the commercially prepared backup formula is: _____

☐ Feeds as directed by Registered Dietitian[4](RD) Name of RD: _____

Intermittent Catheterization - Please detail care requirements (include catheter size and route) and indicate times while at school below:

Routine oral/nasal suctioning- Please detail care requirements (include catheter size, type and route) below:

Routine BG monitoring - Please detail care requirements (include low and/or high BG parameters and treatment protocols, & mandatory/high risk checks) below:

Name of Medications/Additives to Feeds Required at School[1,2]	Dosage	Frequency	Route[3]	Specific Directions for Use

Continued on next page

[1] For recipe-based feeds the order must also include a list of ingredients.

[2] Oxygen administration only if on continuous rate of flow.

[3] Main routes would be G/GJ/J or mask/NP for oxygen administration. T1D related medications on the T1D order form. Seizure rescue intervention medications on the Seizure order form.

[4] As per BCCH policy Nutrition Orders By Dietitians a feeding order can by written by an RD. If written by an RD, the RD writes the order under the delegated authority of the physician. Therefore, the feeding orders must be made in collaboration with the child's MRP/health care team.

ADDITIONAL COMMENTS/POSSIBLE REACTIONS/CONSEQUENCES OF MISSING MEDICATION:

Name of Prescriber (please print)	Role of Prescriber	Signature of Prescriber	Date Signed (YYYY/MM/DD)	Phone Number
	○ MD ○ RD ○ NP			

To Be Completed By Parent Or Guardian

I request the school/child care to give the medication as prescribed in Section B of this form to my child named in Section A of this form

Name of Parent or Guardian

Signature of Parent or Guardian

Date Signed (YY/MM/DD)

To Be Completed By registered Nurse After The Completed Request Is Returned To The School/Child Care

Comments:

Signature of Registered Nurse Date Signed (YY/MM/DD)

EACH TRAINED CAREGIVER RESPONSIBLE FOR ADMINISTERING OR SUPERVISING OF SELF ADMINISTRATION OF MEDICATION		
Name of Trained Caregiver	Signature	Date Signed (YYYY/MM/DD)