Office of Student Health Services
Chesterfield County Public Schools

Order for Colostomy or Ileostomy Management at School

Healthcare Plan/Orders effective for current school year, including summer school.

Revised 7/2025

DOB: _____ **Grade:** _____

Student Name: _____ **School:** _____

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Health Status

Diagnosis:

ICD 10: _____

_____

Type of Procedure ***(circle one):***

Colostomy

Ileostomy

☐ Frequency of pouch drainage: _____ PRN: ☐ yes ☐ no

☐ Times for pouch drainage: _____

☐ What circumstances require bag to be changed at school: _____

_____

☐ Solution used for cleaning stoma site: _____

☐ Will diapering be required: ☐ yes ☐ no (Instructions): _____

Other Special Considerations: _____

Physician Names and Phone Numbers

_____ _____
Primary Physician **Phone Number**

_____ _____
Gastroenerologist **Phone Number**

_____ _____
Other **Phone Number**

This document must be completed in addition to the Individualized Healthcare Plan – General

Licensed Healthcare Provider

_____ _____
Licensed Healthcare Provider Name (Print) / Signature **NPI#** **Phone Number** **Date**

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed and agree to this health plan for my student and understand that school staff /school nurse may communicate with my child's Licensed Healthcare Provider (LHP) regarding this health plan. I acknowledge that I am responsible for providing the school with all medications and supplies required to implement the plan as ordered by the LHP.**

_____ _____ _____ _____
Parent/Guardian Name (Print) **Parent/Guardian (Signature)** **Date** **Phone Number**

_____ _____ _____
School Nurse Name/Signature **Date Received** **Date Emergency Action Plan Distributed**