Snohomish School District No. 201
1601 Avenue D
Snohomish, WA 98290

Parent Request for Clean Intermittent Catherization or Assisted Self-Catherization

Student's Name ________________________________ School _____________________

Parent/Guardian Name __________________________ Grade _____________________

I certify that I am the parent/guardian of the above-identified student and request and authorize the school to provide CIC in accordance with the order and instructions from the licensed medical practitioner for the period commencing with the ______ day of _______________, 20_____ through the ______ day of _________________, 20______.

I have obtained detailed written instructions from ____________________________, the licensed medical practitioner who recommended this service. You have my permission to communicate freely with the licensed medical practitioner in order to make arrangements for the care and supervision of my child.

I understand services will not be started until these orders are on file in my child's school and adequate training of staff has been completed. I agree to provide all necessary supplies and equipment to perform this service.

I understand that this request will not be valid for any period greater than one year or past the end of the current school year, whichever comes first.

I understand that the clean intermittent catheterization may be performed by a medically trained non-licensed individual.

Parent/Guardian Signature ______________________________ Date ________________

Address ____________________________________City _______________ Zip _________

Telephone No. (Home) (_____)_________________(Cell) (_____)______________________

(Work)______________________