Licensed Health Professional's G-Tube Procedure Request at School

Student Name ______________________________ Birthdate ______________________

School ______________________________ Grade ______________________

To Be Completed by a Licensed Health Professional with Prescriptive Authority

Type of Gastrostomy Tube ______________ Size ______ Inflate ______ cc Date of Re-placement ________

Reason for Treatment: ______________________ G-Tube used for ❑ Feeding ❑ Medication ❑ Both

Type of formula/nutrient ______________________________

______________________ Time(s) of feeding(s): ______________ and ❑ PRN

Can student eat/drink anything by mouth? ❑ YES ❑ NO If YES, what? ______________________

Is student on a pump? ❑ YES ❑ NO If YES, what type? ______________ Run at: ________ ❑ ml/hr

If student feeding requires pump, school staff may disconnect feeding for therapies and diapering/toileting? ❑ YES ❑ NO

Aspirate residual before feeding? ❑ YES ❑ NO If YES, return residual if less than ______________ ml

Vent before feedings? ❑ YES ❑ NO If YES, for how long? ______________ Minute(s)

Flush with water after each feeding? ❑ YES ❑ NO If YES, amount ______________ ml

How is feeding usually tolerated? ❑ Good ❑ Poor Position needed for feeding: ______________

Position needed after feeding: ______________________________

If G-Tube is displaced at school. *Check all applicable boxes.*

❑ Parent and/or legal guardian has been trained to replace g-tube

❑ Child must see their doctor or surgeon for reinsertion of the g-tube.

❑ If available, a licensed, trained health professional may replace g-tube.

Hold feedings if: ______________________________

Other instructions: ______________________________

Duration of order(s): ❑ School Year ❑ (mm/dd/yr) ______________ to ______________.

____

Health Care Provider's Signature Phone Fax

____

Health Care Provider's Printed Name or Stamp Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

To Be Completed by the Parent or Legal Guardian

G-Tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes. I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child, *(name of child)*, ______________ the treatment prescribed by *(name of health care provider)* ______________ for the ________ school year. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed
- I understand that I must provide all necessary supplies and equipment to perform this service.

Parent/Guardian Signature: ______________________________ Date: ______________

Phone Contacts: *Home* ______________ *Cell* ______________ *Work* ______________ *Other* ______________