LICENSED HEALTH CARE PROVIDER'S GASTROSTOMY TUBE SCHOOL ORDERS

Student Name:_____ Date of birth:_____

School:_____ Grade:_____

TO BE FILLED OUT BY LICENSE HEALTHCARE PROVIDER:

Type of Gastrostomy tube:_____ Size - Width:_____French Length:_____cm

Inflate with:_____cc water. G-tube used for: ☐ Feeding ☐ Medication ☐ Both

Reason for Treatment:_____ Type of Formula/Nutrient:_____

Time of feeding(s):_____ ☐ PRN_____

Is student on a pump? ☐ Yes ☐ No If yes, what type?_____ Rate: _____mL/hr or at parent direction.

If student feeding requires a feeding pump, staff may disconnect for therapies, toileting/diapering? ☐ Yes ☐ No

Can student eat anything by mouth? ☐ Yes ☐ No If yes, what?_____

Aspirate stomach contents prior to feeding? ☐ Yes ☐ No If yes, return residual if less than _____ccs

Vent before feedings? ☐ Yes ☐ No If yes, for how long?_____

Flush with _____cc water after every feeding/medication administration.

How is feeding usually tolerated? ☐ Good ☐ Poor _____

Position needed for feeding:_____ Position needed after feeding: _____

If G-tube is displaced at school: *Check all appropriate boxes*

- ☐ Parent/guardian has been trained to replace the G-tube.
- ☐ Child must see their doctor or surgeon for reinsertion of G-tube.
- ☐ If available, a licensed, trained health professional may replace G-tube.

Hold feeding if:_____

Other instructions:_____

Duration of order: ☐ School year (including Summer School) ☐ mm/dd/yy _____to_____

_____

Healthcare Provider's Signature *Phone* *Fax*

_____

Healthcare Provider's Printed Name or Stamp *Date*

THIS AUTHORIZATION IS VALID FOR CURRENT SCHOOL YEAR ONLY

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:

G-Tubes that become dislodged or fall out: Please be aware that registered nurses 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:* _____