Coeur d'Alene Public Schools

SCHOOL G-TUBE PROCEDURE REQUEST FORM

SCHOOL YEAR _____ - _____

STUDENT NAME: _____ **Birthdate:** _____

SCHOOL: _____ **Grade:** _____

THIS PORTION TO BE COMPLETED BY LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Type of Gastrostomy Tube: _____ Size: _____ Inflate: _____ Date of Replacement: _____

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

Type of formula/nutrient: _____

Time(s) of feeding(s): _____ and ❑PRN Water Bolus? ❑Yes ❑No If Yes, amount? _____mL Frequency: _____

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 & diapering/toileting? ❑Yes ❑No

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: Call parent/guardian immediately. If not able to come to replace the tube, or do not arrive within two hours from removal, call EMS to transport the student to the hospital (Emergency Department) for replacement.

Hold feedings if: _____

Other instructions: _____

I request/authorize the above named student be administered the above named procedure in accordance with the instructions indicated above from _____ to _____ or the entire school year including summer months (if applicable), as there exists a valid health reason which makes the procedure advisable during school hours. **Orders are valid for the current school year only.**

Date of Signature: _____ **Licensed Health Professional's Signature**: _____

Phone #: _____ Fax: _____ LHP's Name (print): _____

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I have read and understand the parent information regarding medication at school (school office) and request/authorize trained school staff to care for my child in accordance with the LHP's instructions above for the dates of _____ to _____ or one entire school year including summer months (if applicable). Orders are valid for the current school year only.

I understand that school staff do not have universal training to replace dislodged g-tubes. I understand that I must provide all necessary supplies and equipment to perform this service. I understand that the procedure will not begin until adequate training of qualified staff is completed. I will notify the school immediately with any changes or cancellations. 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 give my permission for the exchange of information between school district nurse and Licensed Health Professional for the purpose of clarifying orders/concerns that could affect safe administration at school.

Date of Signature: _____ Parent/Guardian Signature _____

Home Phone: _____ Work/Cell Phone: _____ Alternate Phone: _____