CACHE COUNTY SCHOOL DISTRICT

Authorization of School Personnel to Administer Gastrostomy (G-Tube)/Gastrostomy-Jejunostomy (G-J Tube) Tube Procedures

CACHE COUNTY SCHOOL DISTRICT
Nursing & Health Services
Phone 435-752-3925
Fax 435-792-7796

ATTACH STUDENT PHOTO

STUDENT INFORMATION

Student:	School:	DOB:	Grade:
Parent:	Phone:	Email:	
Prescriber Name:	Phone:	Fax:	
School Nurse:	Phone:	Fax:	

SECTION 1: Health Care Provider's Statement/Order Student has: ☐Nissen ☐Potential for reflux

Diagnosis: _____ Student has: ☐G-Tube ☐G-J Tube

FEEDING ORDER DURING SCHOOL

Name of Formula: _____ ☐Prepared by parent **OR** ☐Water flush only

By: ☐Syringe bolus (gravity) ☐Feeding pump bolus ☐Feeding pump

IF BY GRAVITY BOLUS

Volume: _____ mL over _____ minutes. ☐Feeding is required every _____ hours

☐Feeding is required at _____o'clock and _____ o'clock

☐Feeding is required only if student does not each lunch

IF BY PUMP

Pump will be programed by parent. ☐Continuous: Rate set at: _____ mL/hour

☐Pump bolus: Volume _____ mL ☐Rate set at: _____ mL/hour over _____ minutes.

FLUSH: ☐Before feeding and after feeding with _____ mL's room temperature water.

ADDITIONAL HYDRATION

☐Water (room temperature) ☐Volume: _____ mL's over _____ minutes

Administration hydration: ☐G-Tube ☐G-J Tube By: ☐Syringe bolus (gravity) ☐Feeding pump bolus ☐Feeding pump

ADDITIONAL INSTRUCTIONS/COMMENTS

POSITION: ☐Student upright ☐Other: _____

VENT: ☐Yes ☐ No See Individualized Health Care Plan for vent instructions.

MEDICATION'S DURING SCHOOL HOURS: REQUIRED TO USE CCSD MEDICATION AUTHORIZATION FORM

ADMINISTERED via: ☐G-Tube ☐G-J Tube

FLUSH: Before & after medication with _____mL's water. **FLUSH:** In between medications with _____ mL's water

G-TUBE FEEDING AND CARES WILL BE PERFORMED BY STAFF THAT HAVE BEEN TRAINED BY THE SCHOOL NURSE.

HEALTH CARE PROVIDER SIGNATURE: DATE:

SECTION II: PARENT/GUARDIAN REQUEST & APPROVAL

I hereby request and give my permission for the above named student to receive the specified procedure as stated in the instructions from the health care provider. I understand that the above interventions will be provided by trained school employee volunteers. I understand that parent is responsible for maintaining necessary supplies, medication and equipment. Parents and school nurses will train unlicensed and designated personnel to administer the procedure, provide cares and maintain records of all interventions. I further understand that school personnel who provide assistance or employer of such staff are not liable, civilly or criminally for any adverse reaction suffered by my child as a result of procedure. Information will be shared with school staff on a "need to know" basis. Parent is responsible to notify district nurse with any changes in my students care.

PARENT SIGNATURE: DATE: