EVERETT PUBLIC SCHOOLS

GASTROSTOMY TUBE TREATMENT AUTHORIZATION FORM

Student Name:		DOB:
School:	Student #:	Grade:

General Gastrostomy Guidelines

Feedings via a gastrostomy should be performed at school only when absolutely necessary. Whenever possible the parent/guardian and licensed health care provider (LHCP) are urged to design a schedule for feedings outside of school hours. It is understood that trained unlicensed personnel may perform some treatments per state law (tasks delegable per registered nursing licensure).

If a student **must** receive a **feeding** via a gastrostomy during school hours or when the student is under the supervision of school officials, the following procedures must be followed. A gastrostomy may be used once a completed Gastrostomy Tube Treatment Authorization Form, signed by a LHCP and parent/guardian is on file. The request is valid for the current academic school year, including summer school, unless a shorter time period is specified.

G-tubes cannot be reinserted in the school setting by staff at Everett Public Schools. If a G-tube is dislodged at school, the parent/guardian will be contacted to come to the school to reinsert the tube. If parents cannot be reached within 30 minutes and stoma is considered immature (<8wk old), the student will be transported to the emergency room with their emergency G-tube kit. For Mature Stomas, staff will call 911 after 60 minutes for transport to the emergency room. Families are encouraged but not required to provide an Emergency G-tube kit.

Physician Order for Administration of Gastrostomy Feedings During School Hours

Tube type: ☐ Gastrostomy ☐Jejunum ☐Gastrostomy/Jejunum	**Mature Stoma?** ☐Yes ☐No	**Date placed:**

Feeding Recipe/Formula/Solution:

Feeding Recipe/Formula/Solution substitution per family allowed? ☐ Yes ☐ No

Volume, rate, time(s) may be adjusted per parent discretion? ☐ Yes ☐ No

Feeding Time(s): ☐ **Scheduled** ☐ **Continuous*** ☐ **DO NOT pause continuous feeds, or limit to _____.** **Feeds will be paused for therapies, position changes & transfers unless indicated above.*	**Feeding Route:** ☐ G-Tube ☐ J-Tube	**Water Flush after feed?** ☐ Yes-Amount: _____ ☐ No

Bolus Type: ☐ Syringe Push ☐ Gravity/Drip ☐ Pump @ rate_____/hr

Volumes, rate and timing may be adjusted per parent discretion at school? ☐ Yes ☐ No

Positioning: ☐ Sitting upright or semi-reclining ☐ Other:_____

Does G-tube need to be vented at school? ☐ Yes ☐ No ☐ Per parent

Conditions under which feeding should not be given:

PO foods allowed: ☐ Yes ☐ No ☐ Per parent **PO Liquids allowed:** ☐ Yes ☐ No ☐ Per parent	**Diet Requirements (**texture, amount, consistency**):**

LHCP SIGNATURE/ INFORMATION

I request and authorize that the above-named student receive the above-identified medication(s) in accordance with the instructions indicated, beginning with the day ____of ____, 20_____ (not to exceed the current school year). There exists a valid health reason, which makes administration of the medication advisable during school hours.

LHCP Signature:		Date:
LHCP Printed Name:	LHCP Phone:	LHCP Fax:

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

- Due to unforeseen circumstances, I understand a scheduled feeding may be delayed or missed.
- All feeding solutions, supplied by the parent/guardian, must be in the original, properly labeled container.
- My signature below indicates that I have read and understand and will abide by the district medication policy 3416.

➢ Parent/Guardian Printed Name and Signature:		Date:
Home Phone #:	Work #:	Mobile #:

District RN Signature: _____ Date: _____