School Year: _____ - _____

RICHLAND School District

Place student's picture here

MEDICAL FORM: GASTROSTOMY AND/OR JEJUNOSTOMY TUBE
(HEALTH PLAN/MEDICAL 504)

STUDENT NAME: _____ DOB:_____ SCHOOL: _____

Diagnosis_____

MEDICAL PROVIDER TO COMPLETE:

Care of and use of the following tube is permitted at school: ☐ G-Tube ☐ J-Tube Other_____

Indicate whether tube will be at school for: ☐ Feeding ☐ Medication Other _____

Please mark delivery method: ☐ Gravity/Bolus ☐ Pump ☐ Other _____

Name of Formula/food _____ Quantity of formula per feed _____ (mls)

Duration of feeding: Bolus _____ (mins) Pump rate _____ (ml/hr)

Water flush: Before feeding _____ (mls) After feeding _____ (mls)

If by pump, is it okay to administer by bolus if the pump malfunctions at school? ☐ NO ☐ YES
If yes, please note approximate duration of bolus: _____ minutes.

Medication at school (via g-tube) Reason for medication**:** _____

Name/strength: _____ Dose: _____ Time:_____
Route: ☐G /☐J TUBE *If PRN, how long between doses: _____ Side Effects: _____

Additional Information: _____

Call school nurse or primary physician if: Tube site becomes red, tender, has abnormal tissue build-up around the stoma, excessive leakage around tube, or if the tube is not functioning properly. If tube falls out, please cover the site with a gauze bandage and contact parent and nurse immediately.

I request and authorize that the above named student be provided the GI tube care as described above, for the duration of the 2014-15 school year OR for the period commencing___/___/20___ through ___/___/20___ (not to exceed the current school year). Order to be renewed annually.

_____	_____	_____
Medical Provider (Printed Name)	**Provider signature**	**Date**
_____	_____	
Provider Phone	**Provider Fax**	
_____	_____	_____
Registered Dietician/Other (Printed Name) *(optional)*	RD/Other signature	Date

***PLEASE NOTE*:** If this order is completed by a dietician or health professional other than the medical provider, the order must be reviewed, approved, and signed off by the medical provider (ie. MD/DO/NP).

This section to be completed by the child's Parent/Guardian

PARENT/GUARDIAN Contact Information:

Name: _____ Phone: _____

Name: _____ Phone: _____

EMERGENCY CONTACTS (if unable to reach parent/guardian)

Name: _____ Relationship:_____ PH: _____

Name: _____ Relationship:_____ PH: _____

PARENT/GUARDIAN PERMISSION & CONSENT FOR 504 HEALTH CARE PLAN:

• I understand that a 504 meeting with the school nurse must occur. I request to have this meeting
(please intitial one) _____ via telephone OR _____ in person, at my child's school
[Office Use Only: Date of 504 Mtg ___/___/___]

• I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I consent for my child to be evaluated for a health care plan/medical 504 plan. I have received a copy of the Notice of Parent/Student Rights under Section 504 (Form 504-1). I agree with this health care plan/medical 504, consent for the placement outlined, and request designated school personnel to follow this plan as it is written. I understand that if I disagree with this plan, I have the right to request a hearing by filing a written request using the 504-7 form. I understand that this health care plan/medical 504, including the medical treatment/medication orders provided, must be renewed and reviewed annually. I understand that my child will be reevaluated every three years to determine if my child continues to qualify for a school health care plan/medical 504.

• I give health services staff permission to communicate with the LHCP's office about any medical treatment/medication orders that I provide to the school, in accordance with HIPPA/FERPA regulations. I understand that the school may share this care plan with emergency responders if student requires emergency services.

• I give permission for school staff to support my child's nutritional needs as outlined by the health care provider on this oral intake order. I give my permissin for the exchange of information between the health care provider authorizing this oral intake order and the school nurse regarding this care plan.

• My signature indicates my understanding that the school accepts no liability for untoward reaction when the order is followed in accordance with the physician's directions. This authorization is good for the current school year only. Any change in the order must be handled as a new order, with a new form completed by both parent and health care provider. I am the parent or the legal guardian of the child named.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

RICHLAND SCHOOL DISTRICT NOTICE OF PARENT/STUDENT RIGHTS UNDER SECTION 504
(Form 504-1)

The Rehabilitation Act of 1973 ("Act"), commonly referred to as "Section 504," is a non- discrimination statute enacted by the United States Congress. The purpose of the Act is to prohibit discrimination and to assure that disabled students have educational opportunities and benefits equal to those provided to non-disabled students.

This is a notice of your rights under Section 504. This document is not intended to address the rights afforded under the Individuals with Disabilities Education Act ("IDEA") that applies to students eligible for special education services. The Office of the Superintendent of Public Instruction's ("OSPI") Notice of Special Education Procedural Safeguards for Students and Their Families is available through the District's Special Education Department and sets out the rights assured by the IDEA. It is the purpose of this notice to set out the rights assured by Section 504 to those disabled students who have a physical or mental impairment that substantially limits one or more major life activity who do not qualify under the IDEA.

Federal laws and regulations provide parent(s)/guardian(s) and students with the following rights:

1. You have the right to be informed by the District of your rights under Section 504 (the purpose of this notice is to advise you of those rights).

2. You have the right to have your child participate in and benefit from the District's education program without discrimination based on disability.

3. You have the right to receive notice before the District takes any action regarding the identification, evaluation, and/or placement of your child.

4. Your child has a right to an evaluation prior to an initial Section 504 placement and any subsequent significant change in placement. You have the right to refuse consent for the initial evaluation and initial placement of your child.

5. You have the right to have your child receive a free appropriate public education ("FAPE"). This includes your child's right to be educated with non-disabled students to the maximum extent appropriate. It also includes the right to have the District provide related aids and/or services to allow your child an equal opportunity to participate in school activities, educational, and/or related aids and services provided to your child without cost except for those fees imposed on the parent(s)/guardian(s) of non-disabled children.

6. Your child has a right to facilities, services, and/or activities that are comparable to those provided for non-disabled students.

7. You have the right to have evaluation, educational, and/or placement decisions for your child based upon information from a variety of sources, by a group of persons who know your child, your child's evaluation data, and/or placement options.

8. You have the right to have your child be provided an equal opportunity to participate in non-academic and extracurricular activities offered by the District.

9. You have the right to examine your child's education records and obtain a copy of such records. You also have the right to receive a response to reasonable requests for explanations and interpretations of your child's education records.

10. You have the right to request the District to amend your child's education records if you believe that they are inaccurate, misleading, and/or otherwise in violation of the privacy rights of your child. If the District refuses this request, you have the right to challenge such refusal under the Family Educational Rights and Privacy Act ("FERPA").

11. You have the right to request mediation or an impartial hearing with respect to the District's actions regarding your child's identification, evaluation, and/or educational placement with opportunity for parental participation in the hearing and representation by an attorney.

12. If you wish to challenge the actions of the District in regard to your child's identification, evaluation, and/or education placement, you should file a written request for a hearing with Mike Hansen, Student Section 504 Program Coordinator, 615 Snow Ave, Richland, Washington 99352; email to: mike.hansen@rsd.edu using the Request for a Hearing (Form 504-2). A hearing will be scheduled before an impartial hearing officer and you will be notified in writing of the date, time, and place of the hearing.

13. If you disagree with the decision of the impartial hearing officer, you have a right to review that decision by a court of competent jurisdiction. If you prevail in a civil rights action against the District, you have the right to seek the payment of reasonable attorney's fees through the court.

14. You have the right to file a local grievance or complaint with the U.S. Department of Education's Office for Civil Rights or file a complaint in federal court. The address of the Regional Office that covers Richland:

U.S. Department of Education Office of Civil Rights
915 Second Avenue, Room 3310
Seattle, Washington 98174-1099
Phone: (206) 607-1600
Website: www.ed.gov/OCR
Email Address: OCR.seattle@ed.gov