

School Year: _____ - _____



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 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 PERMISSION AND CONSENT:

- 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.
- If medication is prescribed within this plan, the medication is to be furnished by me in the original container, and BROUGHT TO SCHOOL BY AN ADULT. Prescription medication must be labeled by the pharmacy with the name of the patient, health care provider, medication, dosage, and the time of day to be given. I understand medication may be administered by non-licensed trained designated staff members in accordance with state regulations and district policy. I understand that at the end of the school year, an adult must pick up any medication, otherwise it will be discarded.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Contact Information:

Name: _____ **PH:** _____ **PH:** _____ **PH:** _____

Name: _____ **PH:** _____ **PH:** _____ **PH:** _____

EMERGENCY CONTACTS (if unable to reach parent/guardian)

Name: _____ **Relationship:** _____ **PH:** _____ **PH:** _____

Name: _____ **Relationship:** _____ **PH:** _____ **PH:** _____

Order reviewed by the school RN: _____ **Signature** _____ **Date** _____

Richland School District

Section 504 Notice of Parent/Guardian and Student Rights

This is a notice of your rights under Section 504. These rights are designed to keep you fully informed about the district's decisions about your child and to inform you of your rights if you disagree with any of those decisions.

You have the right to:

- Have your child participate in and benefit from the district's education program without discrimination based on disability.
- An explanation of your and your child's rights under Section 504.
- Receive notice before the district takes any action regarding the identification, evaluation, or placement of your child.
- Refuse consent for the initial evaluation and initial placement of your child.
- Have your child receive a free appropriate public education. 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 services to allow your child an equal opportunity to participate in school activities.
- Have your child educated in facilities and receive services comparable to those provided to non-disabled students.
- Have your child receive special education services if she/he needs such services.
- Have evaluation, educational, and 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 placement options.
- Have your child be provided an equal opportunity to participate in non-academic and extracurricular activities offered by the district.
- Have educational and related aids and services provided to your child without cost except for those fees imposed on the parents/guardians of non-disabled children.
- Examine your child's education records and obtain a copy of such records at a reasonable cost unless the fee would effectively deny you access to the records.
- A response to your reasonable requests for explanations and interpretations of your child's education records.
- Request the district to amend your child's education records if you believe that they are inaccurate, misleading, 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.
- Request mediation or an impartial due process hearing to challenge actions regarding your child's identification, evaluation, or placement. You and your child may take part in the hearing and have an attorney represent you. Hearing requests can be made to the district's 504 coordinator.
- Ask for payment of reasonable attorney's fees if you are successful on your claim.
- File a local grievance or a complaint with the U.S. Department of Education Office for Civil Rights.

The person in this district who is responsible for ensuring that the district complies with Section 504 is: Mike Hansen Assistant Superintendent K-5 Education and Assessment