# Request for Medical Documentation – G-Tube Feeding

Date:

Dear Parent/Guardian,

Attached are forms for your child for the upcoming school year. The forms attached are:

1. G-Tube Feeding Care Plan, to be filled out by licensed health care provider

2. Activity Restriction to be filled out by parent if no restrictions, to be filled out by licensed health care provider if there are restrictions

3. Health Care Provider Authorization form for feeding via gravity or pump, and reinsertion of the g-tube, to be filled out by licensed health care provider.

4. List of supplies needed to appropriately care for your child

Please contact the health office if your child requires prescription or over the counter medication during the school day, and the appropriate forms will be sent.

A meeting will be set up for the start of the school year for training regarding your child's health care needs. All required paperwork and supplies needed for the care of your child must be brought to school at that time.

Feel free to contact your school health office with any questions.

Student's Name:

Health Assistant:

School Name:

Phone Number:

Care Plans Attached:

Thank you,

Director of Health Services

BONNIE CONE CLASSICAL ACADEMY

# G-TUBE CARE PLAN

Name ________________________________Birthdate __________________________School_________________

To Be Completed by Licensed Health Care Provider

Name of Formula: ________________________ Amount to be Administered: _______________________________

Feeding administered via ○ Gravity ○ Pump

If feeding is via pump, Pump Type_______________________________ Flow Rate __________________________

Prime tubing with ___________________ mls of_______________________________________________________

Flush amount_______________________________________________________________________________

Time of administration at school_____________________________________________________________________

Is it necessary to measure residual volume? ○ Yes ○ No

If yes, will residual volume alter volume of feeding? _____________________________________________________

Student may self-administer this treatment? ○ Yes ○ No

Replace button if it comes out at school? ○ Yes ○ No (If yes, it is recommended that the balloon not be inflated)

If no, please note recommended action to be taken. _____________________________________________________

Liquids orally at school? ○ Yes ○ No

If yes, How much _____________________________________ How often_________________________________

Date to be discontinued___________________________________________________________________________

I acknowledge that it may be necessary for this procedure to be performed by an individual other than a nurse, and specifically consent to such practice.

**Physician Contact Information:** Phone: __________________________ Fax: ____________________________

Healthcare Providers Signature_________________________________________________ Date_________________

**This form is invalid unless stamped and signed by the healthcare provider*

*Physician's Stamp Here*

I agree with the above care plan and to provide necessary equipment/supplies properly labeled for use in school. I give permission for the staff to communicate directly with the healthcare provider named above regarding this care plan. I will notify the school of changes in procedure or provider.

Parent/Guardian Signature________________________ Phone #______________________ Date_______________

Please document medication count ***with parent present*** below:

| Date | Medication Name | Count | Expiration Date | Parent signature | Employee initials |
|---|---|---|---|---|---|
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BONNIE CONE CLASSICAL ACADEMY

# Medication Administration Record

**Student Name:** ________________________________ **Medication:** ______________________________

*A separate sheet is used for each medication or treatment*

**Key:** A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early

| | AUG | SEPT | OCT | NOV | DEC | JAN | FEB | MARCH | APRIL | MAY |
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Additional Daily Administrations (PRN Meds only):

| Date | Time | Person Administering (Name & Initials) |
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**DISTRICT ACTIVITY RESTRICTION**

Name: _______________________________________ Date of Birth: __________________ Grade: ________________

Diagnosis: ___________________________________________________________________________________

Restrictions from Physical Education and/or recess in excess of 5 days require a healthcare provider's written documentation. In addition, students with certain medical conditions will require a healthcare provider's written documentation.

○ May participate in P.E. / sports / recess.

○ May NOT participate in P.E. / sports / recess until: ____________

○ May participate in P.E. / sports / recess with the following restrictions (please check all that apply):

○ No running

○ No jumping

○ No swimming

○ No climbing

○ No lifting > ____lbs.

○ Indoor activity only when temperature is above ______degrees.

○ No Activity Restrictions through Student's Graduation Year ________________ unless otherwise informed by the student's current Health Care Provider.

Please list any other restrictions not listed above: __________________________________________________________

___________________________________________________________________________________________

These restrictions may change due to changes in his/her status, and you will be notified of any changes

Healthcare Provider Signature ______________________________________________Date________________________

Phone Number _____________________________________________________________________________________

○ I give consent for the exchange of information regarding my child's activity restrictions.

Parent/Guardian Signature ______________________________________________Date___________________________

**HEALTHCARE PROVIDER ORDER FOR PRESCRIBED SERVICES (HPS)**

Name ______________________________Birthdate________________________School__________________________

1. Condition to be treated ______________________________________________________________________________

2. Prescribed Service__________________________________________________________________________________

3. Check One:

- ○ I have reviewed and approved the attached standardized procedures as written.
- ○ I have reviewed and approved the attached standardized procedures with my modifications.
- ○ I have attached my recommendations for standardized procedures.

4. Precautions, possible adverse effects, and recommended interventions: _______________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

5. Time schedule and/or indications for Procedure during school hours. __________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Healthcare Provider Name__________________________________________ Telephone__________________________

Healthcare Provider Signature_______________________________________ Date _______________________________

1. I agree with the above procedure and to provide necessary equipment /supplies properly labeled for use in school. The District and District Personnel will assume no responsibility for the proper maintenance or delivery of the special equipment necessary for this procedure.

2. I specifically request that this procedure be administered by trained members of the school staff.

3. I understand that this procedure may be performed by unlicensed assistive personnel.

4. I will train the staff/unlicensed assistive personnel to administer the procedure prescribed.

5. I will notify the school if the procedure changes, and will get verification of this in writing from the healthcare provider.

6. I grant permission for the school staff to communicate directly with the above named healthcare provider, in regards to any questions or concerns regarding this procedure.

Parent/Guardian Signature________________________________________ Date__________________________________

Phone_________________________________________________________

# Procedure for Gastrostomy Tube Feeding: Gravity Bolus Method

1. Verify procedure is prescribed for student
2. Wash hands
3. Assemble equipment:
    a. Liquid to be given
    b. 60 mL syringe, or other container for feeding
    c. Clamp or cap for end of tubing (optional)
    d. Water (for flush)
    e. Tape (to secure tubing, if necessary)
    f. Gloves
4. Position student for feeding – sitting or lying at a 30-degree angle
5. Wash hands and put on gloves
6. Attach or unclamp extension tubing to vent G-Tube (if prescribed) by inserting the syringe into the tubing
7. Attach or unclamp extension tubing and check residual volume (if prescribed) by inserting the syringe into the extension tubing and gently drawing back on the plunger to remove any liquid that may be left in the stomach. Note volume and return residuals to stomach.
8. Clamp tubing, disconnect the syringe, and removed the plunger from the syringe.
9. Reinsert tip of syringe into extension tubing.
10. Unclamp tube, and allow bubbles to escape.
11. Pour liquid to be given into syringe and allow to flow via gravity, by lifting syringe 6 inches above level of stomach.
12. Continue to pour feeding into syringe as contents empty into stomach.
13. When feeding is completed, pour prescribed amount of water into to syringe and flush tubing.
14. Vent g-tube, if prescribed.
15. Clamp tubing, remove syringe, and reinsert cap to end of extension tubing or remove extension tubing and reinsert cap into button.
16. Apply dressing to cover g-tube, if needed.
17. Remove gloves. Wash hands.
18. If extension tubing is not to be removed, ensure it is secure and tucked inside clothing.
19. Wash syringe and other reusable equipment in soapy water. Rinse thoroughly, dry, and store in clean area
20. Document feeding on log sheet.

Adapted from Supporting Students with Special Health Care Needs: Guidelines and Procedures for Schools, Third Edition, edited by Stephanie M. Porter, Patricia A. Branowicki, & Judith S. Palfrey. (2014, Paul H. Brookes Publishing Co., Inc.)

# Procedure for Gastrostomy Tube Feeding: Pump Bolus Method

1. Verify procedure is prescribed for student
2. Wash hands
3. Assemble equipment:
   a. Liquid to be given
   b. 60 mL syringe (if needed)
   c. Clamp or cap for end of tubing (optional)
   d. Water (for flush)
   e. Extension tubing
   f. Feeding bag set and pump
   g. Tape (to secure tubing, if necessary)
   h. Gloves
4. Position student for feeding – sitting or lying at a 30-degree angle
5. Wash hands and put on gloves
6. Attach or unclamp extension tubing to vent G-Tube (if prescribed) by inserting the syringe into the tubing. Clamp tubing and remove syringe when done.
7. Attach or unclamp extension tubing and check residual volume (if prescribed) by inserting the syringe into the extension tubing and gently drawing back on the plunger to remove any liquid that may be left in the stomach. Note volume and return residuals to stomach. Clamp tubing and remove syringe when done.
8. Pour feeding liquid into feeding back and run liquid through bag and tubing to the tip.
9. Clamp tubing, and attach to g-tube
10. Set proper flow rate.
11. Unclamp tubing and run feeding.
12. When feeding is completed, clamp tubing and stop feeding.
13. Pour prescribed amount of water into to bag, unclamp tubing, and flush tubing (if prescribed).
14. Vent g-tube, if prescribed.
15. Clamp tubing, remove extension tubing and feeding bag, and reinsert cap to g-tube button.
16. Apply dressing to cover g-tube, if needed.
17. Remove gloves. Wash hands.
18. If extension tubing is not to be removed, ensure it is secure and tucked inside clothing.
19. Wash bag and other reusable equipment in soapy water. Rinse thoroughly, dry, and store in clean area
20. Document feeding on log sheet.

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# Procedure for Gastrostomy Tube Feeding: Replacing the MIC-KEY Button

1. Verify procedure is prescribed for student
2. Wash hands
3. Assemble equipment:
    a. Replacement MIC-KEY G-tube
    b. Water soluble jelly
    c. Syringe with 5mL of water (if balloon inflation is prescribed)
    d. Tape (to secure tubing, if necessary)
    e. Gauze (to cover tubing, if necessary)
    f. Gloves
4. Remove the new G-Tube from the package. Fill the balloon with 5mL water (if prescribed). Observe the balloon for leaks. Remove the 5mL water from balloon.
5. Position the student sitting or lying at a 30-degree angle.
6. Wash hands and put on gloves.
7. If the g-tube is still intact, attach syringe to the balloon valve of the g-tube you are replacing and remove the 5mL of water in the balloon.
8. Lubricate around the top of the g-tube and gently remove g-tube from stomach.
9. Lubricate tip of the replacement g-tube and gently guide the new tube into the stoma until it is flat against the stomach.
10. Fill the balloon with 5 mL of water (if prescribed).
11. Wipe away fluid or lubricant from the tube and stoma.
12. If refilling the balloon is not ordered, tape g-tube to stomach.
13. Apply dressing to cover g-tube, if needed.
14. Remove gloves. Wash hands.

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# Gastrostomy Tube Feeding Supplies

1. Formula
2. Large 60 cc syringe
3. Bolus tubing
4. Replacement Mic-Key button kit
5. Water soluble lubrication
6. 2x2 gauze
7. Bolus tubing cleaning supplies

10700 Asbury Chapel Rd, Huntersville, NC 28078 * 704-948-4439