GASTRIC-TUBE
PROCEDURE REQUEST AT SCHOOL
Bethel School District #403

Student Name: ______________________________ Birthdate: ____________________

School: ______________________________ Grade: ____________

TO BE COMPLETED BY A LICENSED HEALTH PROFESSIONAL WITH PRESCRIPTIVE AUTHORITY

Type of Gastrostomy Tube: ____________ Size: _______ Inflate: _ cc Date of Replacement: _________

Reason for Treatment: ______________________ G-Tube used for: ☐Feeding ☐Medication ☐Both

Type of Formula/Nutrient: ______________________________

Amount:______________________ Time(s) of Feeding(s): ______________ and ☐ PRN

Flush with water after each feeding? ☐Yes ☐No If YES, amount ______________ ml

Is student on a pump? ☐Yes ☐No If YES, what type? ______________ Run at: _______ ☐ml/hr

If student feeding requires pump, school staff may disconnect feeding for therapies and diapering/toileting? ☐Yes ☐No

Aspirate residual before feeding? ☐Yes ☐No If YES, return residual if less than ______________ ml

Vent before feedings? ☐Yes ☐No If YES, for how long? __________ Minute(s)

How is feeding usually tolerated? ☐Good ☐Poor Position during feeding: ______________

Position needed after feeding: ______________________________

Can student eat/drink anything by mouth? ☐Yes ☐No If YES, what type? ______________

If G-Tube is displaced at school, ☐ Parent and/or legal guardian has been training to replace G-tube
check all applicable boxes: ☐ Child must see their doctor or surgeon for reinsertion of the G-tube

Hold feedings if: ______________________________

Other Instructions: ______________________________

Duration of order(s): ☐School Year ☐ (mm/dd/yr) ______________ to ______________

____
Health Care Provider's Signature Phone Fax

____
Health Care Provider's Printed Name or Stamp Date

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY

TO BE COMPLETED BY THE PARENT OR LEGAL GUARDIAN

Please be aware that the school staff do not have universal training to replace G-tubes. I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child *(name of child)* ______________________ the treatment prescribed by *(name of health care provider)* ______________________ for the ______________
school year. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed.
- I understand that I must provide all necessary supplies and equipment to perform this service.

Parent/Guardian Signature: ______________________________ Date: ______________

Phone Contacts: Home ____________ Cell ____________ Work ____________ Other ____________