

GRANDVIEW SCHOOL DISTRICT

AUTHORIZATION FOR CARE AND USE OF GASTROSTOMY TUBE (G-TUBE)

Student's name _____ DOB _____
School _____ Grade _____
Diagnosis _____

Indicate whether tube will be used for: Feeding _____ Medications _____ Both _____

Feeding:

Formula or food _____

Quantity & Duration _____

Time(s) of Administration _____

Meds:

Medication _____ Dose _____ Time _____

If PRN, how long between doses _____

Other orders:

Call school nurse or primary physician if g-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 call nurse to replace it.

I request and authorize that the above named student be provided with the g-tube care described above for the period commencing ____/____/200__ through ____/____/200__ .
This order to be renewed annually.

Date of signature

Physician's signature

Phone number

Printed name and Clinic name

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to provide g-tube care to this student beginning ____/____/200__ through ____/____/200__ . (Not to exceed 1 school year)
I understand that the above care may be provided by non-licensed school staff.

Date of signature

Parent's signature

Phone number home

phone number work (or emergency contact)

