



Huber Heights City Schools Health Services

Dear Parent/Guardian

You have informed us that your child has a medical need. Enclosed are forms-which need to be completed by both the Parent/Guardian and your child's physician. These forms are necessary in order for the Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your child to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Pertinent information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your child daily.

To help your child, please let us know of any changes in your child's medical condition or emergency daytime phone numbers.

The following need to be returned to the clinic at your school:

- **Student Health Information Sheet**
- **Physician Order for G-Tube Procedure & Parent/Guardian Statement**
- **Request for medication administration –If medications are to be given**

We are looking forward to a great year with your child!

Please call if you have any questions.

**Health Services
Nurse Line
Huber Heights City Schools
(937)-237-6300 ext:81301
or
call the school the student attends**

Huber Heights City Schools Physician order for Gastric Tube Feedings at School

Student name _____ Date of Birth _____

The treatments needed during school hours are:

- Feeding by **gravity**
- Feeding by **pump**

Procedures for feeding student

1. Position Student:

- Sitting upright or semi-reclining with head at _____ degree angle AND/OR
- Remain elevated for _____ minutes after feeding is administered.

2. Aspirate

- I **DO** order to check for aspirate
If aspirate is greater than _____ cc
 - Feed
 - Delay feeding for _____ minutes and repeat aspiration
 - DO NOT FEED**

If aspirate is greater than _____ cc, contact parent.

- I **DO NOT** order to check for aspirate.

3. Flushing

- I **DO** order the G-Tube to be flushed:
 - o **BEFORE** feeding or medications with _____ cc of water
 - o **AFTER** feeding or medications with _____ cc of water

- I **DO NOT** order G-tube to be flushed.

4. Please specify diet/fluid:

TYPE/NAME OF FORMULA _____
AMOUNT _____ RATE (if pump): _____
Frequency _____ of feeding during the school day:

Please give _____ cc of **FREE WATER** at (indicate time/frequency)

5. Feeding Restrictions

- No restrictions in feeding
- Special feeding needs:
 - o Nothing by mouth. G-tube feeding only
 - o Thickened liquids
 - o Other _____

(Physician Signature)

(Date)

(Physician Name Printed)

(Physician Telephone Number)

Huber Heights City Schools Physician order for Gastric Tube Feedings at School

Student name _____ **Date of Birth** _____

I, the parent/guardian of student named above, hereby request the nurse or trained staff member to administer the above procedures according to physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary. I agree to notify the school if there is any change in the student's status or physician's orders

Parent/guardian signature: _____

Date: _____ **Home phone** _____

work _____ **cell** _____ **e-mail**

Huber Heights City Schools Physician order for Gastric Tube Feedings at School

Student name _____ Date of Birth _____

Student Health Information Sheet

Medical Condition: _____

Allergies _____

(This form will be made available to teachers and appropriate school staff.)

Student's Name: _____ DOB: ____ / ____ / ____

Allergies: _____

School: _____ Teacher: _____ Grade: _____

Bus Rider: Yes No Bus #: AM ____ PM ____ Non-Transported

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Alternate contact person in case of emergency:

Name: _____ Relationship: _____ Phone: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

HISTORY OF MEDICAL CONDITION - Include date of onset and most recent concerns: _____

* MEDICATIONS & TREATMENTS AT SCHOOL: _____

ADDITIONAL COMMENTS: _____

DATE COMPLETED: ____ / ____ / ____ COMPLETED BY: _____

** Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

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REVIEWED BY: _____, RN DATE: ____ / ____ / ____

Huber Heights City Schools Physician order for Gastric Tube Feedings at School

Student name _____ Date of Birth _____

Huber Heights City School Gastrostomy Tube Policy

Gastrostomy Feeding

For any students with gastrostomy tube feedings, a physician will complete and sign orders indicating food, fluids, and/or medications to be administered in the gastrostomy tube at school. Orders must include:

1. Steps to confirm feeding tube placement
2. Frequency, type, and amount of formula
3. Time of the feeding(s)
4. Additional fluid requirements to flush (i.e., to tube and for hydration)
5. Guidelines for withholding enteral nutrition based on results of a check for gastric residuals before bolus or intermittent feeding
6. Student positioning during feeding
7. Directions to follow should the tube become dislodged
8. Emergency procedures
9. Gastrostomy tube stoma care

Written parent/guardian consent is required for all specialized procedures performed in school including gastrostomy feeding and dressing changes.

Gastrostomy tube orders must be updated yearly and whenever there are changes made. This includes changes to the prescribed formulas, times, or medications administered in the gastrostomy tube.

Parents/Guardians are responsible for providing all equipment necessary for feedings

Tube feed formulas must be sent to school in the manufacturer's packaging. Physician's order may state accept feeding from home.

Gastrostomy tube feeding will be administered by licensed health care providers such as a registered nurse, licensed practical nurse or designated, trained school personnel under the direct or indirect supervision of the registered nurse. The student may perform this procedure independently if ordered by licensed prescriber.

Huber Heights City School Dislodgement of Gastrostomy Tube Feeding Device

All students with gastrostomy tubes must have instructions signed by a physician for tube dislodgement in school. Written parent/guardian consent is also required for gastrostomy tube replacement.

Gastrostomy tube dislodgement and replacement instructions school include:

1. Who to call when tube becomes dislodged
2. Specific supplies necessary for tube replacement, including the tube manufacturer and size of device
3. Student-specific instructions for tube replacement
4. Student-specific instructions if the nurse is unable to replace the gastrostomy tube. The nurse will place a dressing over the gastrostomy stoma if he/she is unable to replace the tube.

Parents/Guardians must provide a new gastrostomy tube feeding device for nurses to keep on hand in the event of dislodgement. Parents/Guardians must also provide any additional supplies required for tube replacement.

A physician or nurse practitioner must replace a gastrostomy tube that is new and has never been changed. A registered nurse at school cannot replace a new gastrostomy tube.

In the event of tube dislodgement for students who do not have a signed physician instructions for the replacement, the gastrostomy stoma will be covered with a dressing and parents will be notified immediately.