CELINA INDEPENDENT SCHOOL DISTRICT

HEALTH SERVICES

Physician/Parent Request for Administration of Gastrostomy Tube Feeding by CISD Personnel

Special health care procedures may be administered at school by designated district employees when such treatment is necessary for school attendance. A school nurse or employees designated by the principal may administer prescribed G-tube feedings and/or medication. **Supplies are to be provided in the original container and properly labeled. The parent is to bring this completed form along with the supplies and/or special equipment to the school.**

Name of Student:_____DOB:_____Grade/Homeroom:_____

PARENT/GUARDIAN AND PHYSICIAN SIGNATURES ARE REQUIRED

Please attach any relevant medical history and orders regarding g-tube care and ordered feeds to this document

1. Condition for which prescribed treatment is required:

   _____

   _____

2. Type of gastrostomy device:

   _____

3. Type of formula:

   _____

   _____

4. Dose, Frequency, and duration: (Specify if given by pump or gravity; if by pump, please include rate)

   _____

5. Ordered flush type and frequency:

   _____

6. Can the student take food by mouth? YES/NO
   a. If yes- Does the student need any restrictions or modifications? Please specify:

   _____

   _____

CISD staff will notify the parent or guardian for a healthcare referral if leakage, bleeding, redness, swelling, drainage, tenderness, or hardness around the stoma site; distended abdomen, vomiting or diarrhea; fever> 101°F, tube migration; inability to flush tube or give feedings; or if g-tube comes out. CISD employees will NOT attempt to replace the tube if it becomes dislodged or partially dislodged. Parents will be called, and a physician or parent must verify placement before resuming use at school. Please sign below to acknowledge the above statement and verify that all information is correct.

Physician Name: _____Physician Signature:_____Date:_____

Parent/Guardian Signature: _____ Date: _____