

OLDHAM COUNTY BOARD OF EDUCATION

PARENT and PRIMARY CARE PROVIDER AUTHORIZATION FOR G-TUBE FEEDING

Student: _____ Date of Birth: _____

School: _____ School Year: _____

Type of Feeding Tube: _____ Size: _____

Mature Stoma Site? _____ Surgical Insertion Date: _____

Does student have a NISSEN? _____ High Risk for Aspiration? _____

Name of Formula/Feeding*: _____ *Must be sent to school in labeled, unopened container

Volume to be given: _____ cc over _____ minutes

Bolus feeding? [] yes [] no other: _____

Volume of water prior to feeding: _____ cc; after feeding: _____ cc

Feeding times: _____, _____, _____, _____

Position during feeding: _____ after feeding: _____ for _____ minutes

Residual Check: [] yes [] no

If residual is greater than or equal to _____, then action to be taken is: _____

EMERGENCY PLAN OF ACTION:

School staff including nurses cannot forcefully flush or replace a tube into the stomach. The parent/guardian will be notified immediately if a tube becomes clogged or dislodged. School staff will cover the site with gauze and secure with tape. If unable to reach parent/guardian within 30 minutes of tube becoming dislodged AND/OR they are unable to get to school within 1 hour of tube becoming dislodged, EMS 911 will be called. Parent/guardian is responsible for first tube feeding after replacement of tube.

Printed name of MD, APRN, or PA Address

Signature of MD, APRN, or PA Phone Date

*Note to parent/guardian: Signing this form shall release the Oldham County School Board and its employees/staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the health care provider. I agree to communicate in writing changes affecting the medical status or medical history concerning this student related to this plan of care to the Oldham County Board of Education, Health Services Department.

Parent/Guardian Signature Phone Date

Emergency Contact Relationship Phone