

## Authorization to Use and Disclose Health/Service Information Release of Information (ROI) Form

<b>Student</b>	Student Name: _____ Birth Date: _____ _____														
<b>Released By</b>	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student														
<b>Released To</b>	I authorize: This/these entity(ies) (name/address of recipient(s)): Attention: _____ Address: _____ Phone: _____ To use and/or disclose a copy of the health/service information described below for the above named student														
<b>Purpose</b>	For the purpose(s) of: <input type="checkbox"/> This information may be used or disclosed in connection with mental health treatment/services and healthcare operations. <input type="checkbox"/> Other purposes (specify each purpose): _____ _____														
<b>Information to be Disclosed</b>	Description or nature of information to be used and/or disclosed: (check all that apply) <input type="checkbox"/> Assessment/Intake Summary <input type="checkbox"/> Psychiatric Reports <input type="checkbox"/> Service/Treatment Plan <input type="checkbox"/> Progress Report <input type="checkbox"/> Safety/Crisis Plan <input type="checkbox"/> Other records(specify): _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;"> <b>Mental Health</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> N/A         </td> <td style="padding: 5px;">           My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.         </td> </tr> <tr> <td style="padding: 5px;"> <b>Substance Use</b>  <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> N/A         </td> <td style="padding: 5px;">           My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.         </td> </tr> </table>	<b>Mental Health</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding mental health diagnosis and/or treatment. I give my specific authorization for these records to be released.	<b>Substance Use</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	My records may contain information regarding diagnosis and/or treatment for drugs, alcohol use, substance use. I give my specific authorization for these records to be released.										
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<b>Notices</b>	I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, sexually transmitted diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information. I understand that I may revoke this authorization in writing at any time.														
<b>Expiration</b>	I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.  Unless sooner revoked, this authorization is valid for 180 days from the signature date below, or for the following time period:  Date: _____														
<b>Signatures</b>	I have read this authorization, I understand it and I have been offered a copy. A minor patient's signature is required in order to release the following information: (1) HIV/AIDS status, diagnosis, treatment 14 years of age; (2) family planning/abortion no age limit; (3) alcohol/drug treatment 13 years of age; and (4) mental health services 13 years of age.  <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; border-bottom: 1px solid black; text-align: center;">Signature of student</td> <td style="width: 20%; border-bottom: 1px solid black; text-align: center;">Date</td> <td style="width: 40%;"></td> </tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Signature of legal/personal representative</td> <td style="border-bottom: 1px solid black; text-align: center;">Relationship to student</td> <td style="border-bottom: 1px solid black; text-align: center;">Date</td> </tr> </table> <table style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 25%; background-color: #cccccc;">Update of Authorization</td> <td style="width: 45%; background-color: #cccccc;">Signature 1: _____</td> <td style="width: 15%; background-color: #cccccc;">Date: _____</td> <td style="width: 15%;"></td> </tr> <tr> <td style="background-color: #cccccc;"></td> <td style="background-color: #cccccc;">Signature 2: _____</td> <td style="background-color: #cccccc;">Date: _____</td> <td></td> </tr> </table>	Signature of student	Date		Signature of legal/personal representative	Relationship to student	Date	Update of Authorization	Signature 1: _____	Date: _____			Signature 2: _____	Date: _____	
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**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 \_\_\_\_\_

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Health Care Provider's Signature \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

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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 \_\_\_\_\_



**TUBO GÁSTRICO**  
**SOLICITUD DE PROCEDIMIENTO EN LA ESCUELA**  
**Distrito Escolar de Bethel #403**

Nombre del estudiante: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_

Escuela: \_\_\_\_\_ Grado: \_\_\_\_\_

**PARA SER COMPLETADO POR UN PROFESIONAL DE SALUD CON LICENCIA CON AUTORIDAD PRESCRIPTIVA**

Tipo de tubo gástrico: \_\_\_\_\_ Talla: \_\_\_\_\_ Inflable: \_\_ cc Fecha del reemplazo: \_\_\_\_\_

Motivo del tratamiento: \_\_\_\_\_ El tubo G se usa para:  Alimentación  Medicina  Ambos

Tipo de fórmula/nutriente: \_\_\_\_\_

Cantidad: \_\_\_\_\_ Hora(s) de alimentación: \_\_\_\_\_ y  PRN

¿Se debe de enjuagar con agua después de cada alimentación?  Si  No En caso afirmativo, cantidad \_\_\_\_\_ ml

¿Tiene el estudiante una bomba?  Si  No En caso afirmativo, ¿qué tipo? \_\_\_\_\_ Corre a (velocidad): \_\_\_\_\_  ml/hr.

Si la alimentación del estudiante requiere una bomba ¿puede el personal de la escuela desconectar la alimentación para terapias y cambiar pañales/ir al baño?  Yes  No

¿Se debe aspirar los residuos antes de dar la alimentación?  Si  No En caso afirmativo, el retorno residual que sea menor de \_\_\_\_\_ml

¿Ventilar antes de las comidas?  Si  No En caso afirmativo, ¿por cuánto tiempo? \_\_\_\_\_ minuto(s)

¿Cómo suele tolerar la alimentación?  bien  pobremente posición durante la alimentación: \_\_\_\_\_

Posición necesaria después de la alimentación: \_\_\_\_\_

¿Puede el estudiante comer/beber algo por vía oral?  Si  No En caso afirmativo, ¿qué tipo? \_\_\_\_\_

Si el tubo G se lleva a la escuela,  El padre y/o tutor legal ha sido entrenando para reemplazar el tubo G

Marque todas las que aplican:  El estudiante debe ver a su médico o cirujano para la re inserción del tubo G

Pare/suspenda la alimentación si: \_\_\_\_\_

Otras instrucciones: \_\_\_\_\_

Duración del servicio(s):  Año escolar  (mm/dd/aa) desde \_\_\_\_\_ hasta \_\_\_\_\_

Firma del proveedor de atención médica \_\_\_\_\_ Teléfono \_\_\_\_\_ Fax \_\_\_\_\_

Nombre del proveedor de atención médica en letra imprenta o sello \_\_\_\_\_ Fecha: \_\_\_\_\_

**ESTA AUTORIZACIÓN ES VALIDA SOLO PARA EL AÑO ESCOLAR ACTUAL**

**PARA SER COMPLETADO POR EL PADRE O TUTOR LEGAL**

Por favor, tenga en cuenta que el personal de la escuela no tiene capacitación universal para reemplazar los tubos G. Solicito que se le permita a la enfermera de la escuela o a la persona designada del personal a hablar sobre los problemas médicos de mi estudiante con los proveedores de atención médica y suministrar a mi estudiante (*nombre del estudiante*) \_\_\_\_\_ los tratamientos ordenados por (*Nombre del proveedor de atención médica*) \_\_\_\_\_ para el \_\_\_\_\_ año escolar. Con mi firma certifico que entiendo que la escuela no acepta ninguna responsabilidad por reacciones adversas cuando el tratamiento se administra de acuerdo con las instrucciones de atención medica del proveedor y **que recogeré al final del año escolar todos los suministros y equipos necesarios, de lo contrario serán destruidos.** Yo soy el padre/tutor legal del estudiante nombrado anteriormente.

- Notificare inmediatamente a la escuela cualquier cambio o cancelación.
- Entiendo que los servicios no comenzarán hasta que se complete la capacitación adecuada del personal calificado.
- Entiendo que debo proporcionar todos los suministros y equipos necesarios para realizar este servicio.

Firma del padre/tutor: \_\_\_\_\_ Fecha: \_\_\_\_\_

Número de teléfono del contacto: Casa \_\_\_\_\_ Celular \_\_\_\_\_ Trabajo \_\_\_\_\_ Otro \_\_\_\_\_