Clint ISD School Health Services
Gastrointestinal Specialized Healthcare Procedures Practitioner's Written Order

Student's Name: _____ DOB: _____

School: _____ Year: 20 _____ - 20 _____

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the above school year or until there is a change or cancellation of the procedure(s).

Medical Diagnosis: _____

Allergies: _____

Enteral Feedings

Formula Name :_____

Enteral Tube type:_____

Enteral Tube size:_____

Feeding via:
- ☐ NG
- ☐ J/T
- ☐ PEG

Deliver feedings via:
- ☐ Pump
- ☐ Bolus
- ☐ Gravity
- ☐ Continuous

Bolus delivery: _____ ml or # of cans ____ times per day or q _____ hrs

For Continuous delivery: _____ ml per hours _____hours a day

Downtime _____am/pm to_____ am/pm _____ none

Flush tube with _____ml of water q____ hrs

Total volume of nutrient + flush = ____ ml/24 hrs

Flush tube with _____ml of water after each medication between each medications

Medication/s: Name	Dose	Time	Route
_____	_____	_____	_____
_____	_____	_____	_____

Residual

Check for residual q ____hrs

If ____ ml or over, hold feeding for ____ hrs/min then resume feeding and recheck residual in _____ hrs

If residual _____ ml or over _____, notify MD and contact parent

Placement:

Check tube for proper placement: (NG Tube)

- ☐ Prior to each feeding
- ☐ Prior to flush
- ☐ Prior to medication administration

Care: Cleanse site daily with the following topical

Ointment_____ q_____ hrs/PRN

Dislodgment Care: If the device is dislodged CISD procedure is as follows. Parent immediate notification for possible reinsertion, Physician notification, site covered with a gauze pad and activation of emergency services if needed

Student specific instructions for procedure/Treatment/Recommendations/Other: _____

_____

_____

_____

Oral Intake

☐No ☐Yes Student may have fluid/food by mouth:
- ☐ Thickened
- ☐ Pureed
- ☐ Liquid
- ☐ Chopped

Quantity of P.O. Fluids if applicable :

_____

_____

Ileostomy /Colostomy

Stoma Care: Apply the following medication

Medication Route Dosage Time

_____

_____

Diet restrictions: _____

_____

Appliance size, barrier, paste, etc.

_____

Other: _____

_____

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Practitioner's Name_____

_____ _____ _____

Practitioner's Signature **Office Phone Number** **Date**

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To be completed by Parent/Guardian/Debe ser completado por Padre/Tutor

Authorization and Consent for Services
I request and authorize the school nurse and trained school personnel to perform or monitor the above ordered procedure as prescribed by my child's physician. I will provide the school with the necessary supplies/equipment to perform this service for my child. I will also provide written notification from the physician if the treatment changes or is discontinued. This authorization will be in effect for the above stated school year.

_____ _____
Parent/Guardian Signature **Date**

Autorización y Consentimiento Para Servicios
Solicito y autorizo a la enfermera y al personal escolar capacitado a realizar o supervisar el procedimiento prescrito por el médico de mi hijo/a, mencionado anteriormente. Proporcionare a la escuela con los suministros/equipos necesarias para llevar a cabo este servicio para mi hijo. También proporcionaré la notificación por escrito del médico si el tratamiento cambia o se discontinúa. Esta autorización estará en efecto para el susodicho año escolar indicado.

_____ _____
Firma del Padre/Tutor **Fecha**

Authorization to Release and Obtain Medical Information
I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

_____ _____
Parent/Guardian Signature **Date**

Autorización Para obtener y Divulgar Información Médica
Autorizo la divulgación de información sobre los procedimientos y servicios especializados de salud relacionados con la condición de mi hijo entre el médico tratante de mi hijo/a, la enfermera de la escuela y personal de la escuela que necesita tener esta información para mantener la seguridad, la salud y el cuidado de mi hijo/a. Esta autorización estará en efecto para el susodicho año escolar indicado.

_____ _____
Firma del Padre/Tutor **Fecha**