

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR GASTROSTOMY TUBE CARE

School Year: _____

STUDENT INFORMATION

Student's Name _____ Date of Birth _____

School _____ Grade _____ Teacher _____ School Year _____

Any known drug allergies/reactions? ☐ Yes ☐ No If yes, please list: _____

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider) *ALL ORDERS ARE GOOD FOR ONE CALENDAR YEAR UNLESS OTHERWISE NOTED WITH "STOP DATE"*

START DATE: _____

STOP DATE: _____

Type Formula	Reason for Taking	Route: Enteral	Amount per feeding: _____ ml.	Frequency/Time(s)
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RESIDUAL and FLUSH:

Check residual before feeding? Yes ☐ No ☐ Notify prescriber if residual is greater than _____ ml? Yes ☐ No ☐	Flush before formula? Yes ☐ _____ ml. No ☐ Flush after formula? Yes ☐ _____ ml. No ☐	Flush before medication administered? Yes ☐ _____ ml. No ☐ Flush after medication is taken? Yes ☐ _____ ml. No ☐
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STORAGE: Formula requires refrigeration after opening? Yes ☐ No ☐ Syringe/tubing stored in refrigeration? Yes ☐ No ☐Self care is permitted and recommended for this student? *Yes ☐ No ☐

*If YES, I hereby affirm that this student has been instructed in the proper self-administration of the prescribed formula.

If yes, do you recommend equipment, supplies and/or formula be kept "on person" by the student? *Yes ☐ No ☐

TYPE TUBE:

Mic-Key Button, Foley, Other:	Lumen size: _____ French	Length: _____ cm.	Balloon size: _____ ml.
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Is student's stoma considered a mature stoma (At least 6-8 weeks post op)? Yes ☐ No ☐ *Date stoma considered mature: _____

- If the gastrostomy button or tube becomes dislodged after this date*, the school nurse, who has received specialized training approved by the Alabama Board of Nursing, will reinsert the gastrostomy tube/button or appropriate sized Foley catheter, tape it into place and contact the parent. The nurse will NOT inflate the tube/button or Foley balloon and will NOT provide an enteral feeding following reinsertion.
- If the gastrostomy button or tube becomes dislodged before this date*, the school nurse will immediately call the parent and prescriber. The parent or guardian will be responsible to pick up the student. The nurse will NOT attempt to reinsert the button. If bleeding from the stoma site, difficulty breathing or any change in status occurs 911 will be called immediately.

Treatment Order (Site Care, Dressing Change): _____
(Attach additional sheet or use the back of this form if necessary)

Printed Name of Licensed Healthcare Provider _____

Signature of Prescriber _____

Date _____

Phone _____

Fax _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to talk with the prescriber or pharmacist should a question come up about the procedure. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment and/or supplies must be registered with the school nurse, principal, or his/her designee. Formula must be in the original, unopened, sealed container and be properly labeled with the student's name.

Signature of Parent _____

Date _____

Phone _____

Cell _____

SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).

Signature of Parent _____

Date _____

Phone _____

Cell _____