Parent Consent and Authorized Healthcare Provider Authorization for Management of Gastrostomy at School and School-sponsored Events

Pupil:	**DOB:**	**Date:**
School:	**Teacher/Rm:**	**Grade:**
Medical office:	**Patient Identification #:**	

1. Type of feeding device

☐ Gastrostomy tube—Type: _____
Size: _____ Adjusted tube length: _____

☐ Gastrostomy button
☐ MIC-KEY ☐ BARD ☐ Other: _____
Size: _____

2. Gastrostomy Feeding

- Time(s) of feeding: _____
- Type of formula: _____ Amount/feeding: _____
- Water—Amount before feeding: _____
  Amount after feeding: _____
  Other: _____
- Duration of each feeding: _____
- Feeding method:
  ☐ Bolus
  ☐ Slow-drip: ☐ Gravity rate: _____
  ☐ Pump rate: _____
- Pupil's position during feeding: _____

3. Residual

☐ Check residual ☐ Residual check not necessary
☐ Feed if residual < _____
☐ Hold feeding if residual > _____
Additional instructions: _____

4. Medication administered via g-tube at school: ☐ No
☐ Yes [medication authorization(s) attached]

5. Decompression: ☐ **Not needed**
☐ Before feeding ☐ After feeding ☐ During feeding
☐ PRN for signs/symptoms: _____
Duration of decompression: _____

6. If gastrostomy tube becomes dislodged:
☐ Cover site and notify parent
☐ Reinsert gastrostomy tube by RN/LVN
☐ Reinsert skin-level button by RN/LVN
☐ Unlicensed trained school staff may follow procedure using catheter to maintain temporary ostomy patency.
☐ Other: _____
Reinsertion must occur within: _____

7. Fundoplication: ☐ No ☐ Yes; date: _____

8. Oral feedings

Feeding evaluation: ☐ Yes (copy attached) ☐ No
☐ NPO (nothing by mouth)
☐ Tiny tastes of food/liquids
☐ Thin liquids (i.e. formula, milk, juices, water, popsicle)
☐ Thick liquids (i.e. nectar, milk shake, ice cream, yogurt, thickened juices)
☐ Thickener: _____ Amount: _____
☐ Pureed foods (i.e. applesauce)
☐ Other: _____

9. ☐ Other pertinent information/ recommendations signed and attached to authorization form.

Authorized Healthcare Provider Authorization for Management of Gastrostomy In School Setting

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical healthcare services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name** _____**Signature** _____

Date_____ **Phone** _____ **Address** _____**City** _____**Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Supervising Physician Name _____ **Address** _____ **Phone** _____

☐ I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

Parent Consent for Authorization and Management of Gastrostomy in School Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request that the specialized physical healthcare service, gastrostomy management, be administered to my (our) child in accordance with state laws and regulations. I (we) will:

1. provide the necessary supplies and equipment;
2. notify the school nurse if there is a change in child's health status or attending authorized healthcare provider; and
3. notify the school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized healthcare provider when necessary.
I (we) understand that I (we) will be provided a copy of my child's completed Individualized Healthcare Plan (IHP).

Parent(s)/Guardian(s) Signature _____**Date** _____

_____ **Date**_____

Reviewed by school nurse (signature) _____ **Date** _____

☐ **School nurse has informed principal about healthcare services provided for this pupil.**