ALEDO INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES
1008 BAILEY RANCH ROAD
ALEDO, TEXAS 76008

AUTHORIZATION FOR GASTROSTOMY MANAGEMENT DURING SCHOOL HOURS

Student Name: _____ Grade: _____ DOB: _____ /_____ /_____

TO BE COMPLETED BY PHYSICIAN:
Student condition requiring gastrostomy feeding: _____
Type of button/tube: _____ Date Placed: _____

Tube Feedings/Flushes:

- Type of formula to be given via Gastrostomy tube/button:
  - ☐ Pre-packaged formula: _____
  - ☐ Homemade formula (Parent prepares at home according to physician orders)
- Amount of formula to be given at each feeding: _____
- Times to be administered: _____
- Position during feeding: _____
- Administration method:
  - ☐ Gravity or bolus feed over a period of _____ minutes.
  - ☐ Infusion pump at a rate of _____ mL per hour.
- Flushes:
  - ☐ Use: ❑ Tap water ❑ Sterile water ❑ Other: _____
  - ☐ When: ❑ Before feeding ❑ After feeding ❑ Additional times: _____
  - ☐ Amount: _____
- Residual check necessary: ❑YES ❑NO
  - ☐ Hold feeding if residual is greater than _____ mL.
- Venting/decompression necessary: ❑YES ❑NO
  - If yes, procedure for venting/decompression:
    _____
- Positioning and activity following feeding: _____
- Has the student had a fundoplication? ❑YES ❑NO
- When to hold feeding: _____

Medications via Tube:

- Will there be medications administered via gastrostomy tube/button at school? ❑YES ❑NO
  - If yes, please complete the Aledo ISD Medication Administration Request form.
- Flush with _____ mL of tap water after medication administration via tube/button.

Tube Dislodgement:

- School staff will not place or reinsert enteral feeding tubes in the school setting. In the event a tube becomes dislodged in the school setting, the tube will either be removed and stored in a baggie or temporarily secured in the stoma opening to maintain patency until the parent/guardian can replace the tube and verify placement per physician direction.
- **What action(s) should the parent/guardian take to replace the dislodged tube and verify placement prior to the school resuming use?** _____

Oral Feedings:

- This student ❑MAY ❑MAY NOT have foods/liquids by mouth.
    - If yes, please complete the Aledo ISD Eating and Feeding Evaluation form.
- Has the student had a recent swallow study? ❑YES ❑NO
    - If yes, when and what were the results?

      _____

      **Please provide a copy of the physician report of the swallow study to the school nurse.*

_____ _____ _____

PHYSICIAN NAME (PRINT) PHYSICIAN SIGNATURE DATE

_____ _____

CLINIC/FACILITY PHONE

TO BE COMPLETED BY PARENT/GUARDIAN: (Initial & sign below)

_____ It is the parent/guardian's responsibility to provide all the necessary supplies and equipment as ordered by the physician.

_____ It is the parent/guardian's responsibility to notify the school of any changes to these orders.

_____ This order is good for the current school year and must be renewed each school year.

My signature below indicates that I request Aledo ISD staff to administer the gastrostomy treatments specified above to my child, and I am giving permission for Aledo ISD staff to contact the physician for additional information, if needed.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE