

San Mateo Union High School District
SPECIALIZED PHYSICAL HEALTH CARE SERVICES (SPHCS)
By School Personnel
Physician's Authorization for Gastrostomy Procedure

Student Name: _____ Date of birth: _____ Grade: _____
School: _____ Phone #: _____ Fax #: _____

Parent or Physician to Complete:

1. **Type of Feeding Device:** ☐ Jejunostomy Tube ☐ Gastrostomy tube
☐ Gastrostomy button (choose type): ☐ Mic-Key ☐ Bard ☐ Other: _____
2. **Formula Feeding:** Type: _____ Amount: _____ Time(s): _____
3. **Feeding Method:** ☐ Syringe ☐ Slow-drip from bag at rate: _____ ☐ Drip from pump at rate: _____
4. **Residual:** ☐ Residual check is not necessary ☐ Check residual ☐ Feed if residual is less than _____
☐ Hold the feeding if the residual more than: _____
5. **Water/Flush:** Amount before feeding: _____ Amount after feeding: _____ : _____ Other _____
6. **Decompression:** ☐ No ☐ Yes ☐ *only* for these signs/symptoms: _____ Length of decompression time: _____
7. **Feeding by mouth (check one only):** ☐ Nothing by mouth (NPO) ☐ Tiny tastes of food/liquids
☐ Thin liquids (formula, milk, juice, water, popsicles broth)
☐ Thick liquids (nectar, thick milkshakes, ice cream, yogurt, thick juices): Thickener: _____ Amount: _____
☐ Pureed foods (e.g., applesauce)
☐ Solids (e.g. chopped meat, spaghetti, crackers, bread)
☐ No restrictions ☐ Other: _____
8. **Signs or symptoms that may indicate an emergency situation:** _____
9. **Any 24-hour Calorie recommendation?** _____ **Any 24-hour Fluid recommendations?** _____
10. **Any medication via G-tube at school?** ☐ No ☐ Yes - I gave doctor a *Physician Authorization for Medication* form to sign

Parent Name (completing form): _____ **Date:** _____ **Telephone:** _____

Physician to Complete:

11. **Verification of parent information: I verified (or modified, as shown) all items, 1-10, in the above box:** ☐ No ☐ Yes
12. **If medication administered thru G-tube, I've completed a *Physician Authorization for Medication* form:** ☐ No ☐ Yes
13. **If gastrostomy tube becomes dislodged:**
☐ Cover site; notify parent ☐ Reinsert G-tube ☐ Reinsert skin level button ☐ Insert red rubber catheter
☐ Other: _____
14. **This district's Gastrostomy Procedure:** ☐ Please send me a copy ☐ I have a copy and approve as is ☐ I request modifications to Procedure: _____
15. **Other instructions:** _____

Physician's Name: _____ **Signature:** _____ **Date:** _____
License No.: _____ **NPI #:** _____ **Office Tel #:** _____ **Office Fax #:** _____

I authorize the school nurse, or other appropriately assigned school staff, to administer the medication/perform the procedure, as prescribed here in by the authorized health care provider. I will notify the school immediately and submit a new form, if there are any changes in the medication, procedure or the prescribing physician. I understand that school health staff are obliged by law to clarify issues associated with this order with the prescribing provider as necessary.

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

San Mateo Union High School District

MEDICAL EMERGENCY INSTRUCTIONS / HEALTH CARE PLAN

Student: _____ DOB: _____ School Year: _____

PARENT/GUARDIAN INSTRUCTIONS: As parent/guardian of the above named student, in the event of any emergency, request and instruct the school to **immediately**, as appropriate to the situation:

- Notify Parent/Guardian _____
Phones: Home (____) _____ Work (____) _____ Cell/Pager (____) _____
- Notify Parent/Guardian _____
Phones: Home (____) _____ Work (____) _____ Cell/Pager (____) _____
- Notify doctor _____ Phone (____) _____
- Transport to hospital (specify) _____
Other instructions:

(I) (We) the parent(s) or guardian(s) of the above-named student, hereby indemnify and hold harmless from any demands, actions, suits, or any liability of any nature or kind, any and all personnel, employees, and agents of said district who may act pursuant to the instruction of the child's physician.

SIGNATURE OF PARENT/GUARDIAN

DATE

PHYSICIAN INSTRUCTIONS: The above named student is currently under my care for (medical condition):

Signs/symptoms indicating a medical emergency are:

Actions to be taken:

SIGNATURE OF PHYSICIAN/HEALTH CARE PROVIDER

DATE

NAME & ADDRESS STAMP:
REQUIRED

Phone (____) _____ Fax (____) _____ E-mail: _____

SAN MATEO UNION HIGH SCHOOL DISTRICT
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services at school.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named student's medical record to and from:

San Mateo Union High School District **650 North Delaware St., San Mateo, CA 94401**

School District to which disclosure is made Address/City and State/Zip Code

Sara Devaney, Health Services Manager **650-558-2222 (Confidential Fax 650-762-0250)**

Contact person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following: ☐ All health information; or ☐ Disease-specific information as described:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS: California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that the School District will protect this information as prescribed by the Family Educational Rights Privacy Act (FERPA) and state law and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs. *If you move to another School District, records will be transferred automatically to that School District.*

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the School District or others have acted in reliance to this Authorization.*

APPROVAL: _____
Printed Name Signature Date

Relationship to Patient/Student

Area Code and Telephone Number