Delphos City Schools

HEALTHCARE PROVIDER AUTHORIZATION AND RECOMMENDATION FOR TUBE FEEDINGS

NAME OF STUDENT: _____ DATE OF BIRTH: _____

BLDG. _____ GRADE: _____ TEACHER : _____

STUDENT ADDRESS: _____

STUDENT DIAGNOSIS: _____

TYPE OF FEEDING TUBE: ❑ G-tube ❑ G/J-tube ❑ Other: _____

❑ Feedings and/or Flushes are not administered while at school- do at home (May skip to Parent & Physician Signatures)

This is to certify that the above named student is under my care and needs to receive gastrostomy or gastrojejunostomy tube feedings during school hours as ordered below. I understand that some of these feedings may be administered by medically unlicensed school staff that will be trained and monitored by the school nurse.

Beginning Date for Order: _____ End Date for Order: _____

TUBE FEEDINGS:

Time(s) to Administer	Type and Amount of Feed	Amount of water	Rate to Feed (as bolus over ___ min or as continuous feed over ____)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please note position of student: During feeding: _____

After feeding: _____

Precautions, possible complications, and recommended interventions. (note that school staff do not reinsert G or GJ tubes): _____

_____

Other comments: _____

_____

Additional tube feeding/emergency supplies must be provided. Find them: ❑ In nurses clinic ❑ With student at all times

During school hours, it is my understanding that the school secretary, principal, school nurse AND/OR the above stated child will administer the prescribed medication according to the specified physician's recommendation. The school nurse may contact this physician at any time for information about my child's condition. I agree to submit a revised statement signed by the prescriber if any of the information provided on this form changes. This form is valid for the current school year only and will serve as a Medical Release Form between school and healthcare provider.

(Parent and Physician signatures required below)

Parent Signature: _____ Phone: _____ Date: _____

Physician Signature: _____ Phone: _____ Date: _____

EMERGENCY PROCEDURES FOR FEEDING TUBES

STUDENT NAME: _____ **DATE OF BIRTH:** _____

TYPE OF FEEDING TUBE: ❑ G-tube ❑ G/J-tube ❑ Other: _____

IF FEEDING TUBE BECOMES DISLODGED AT SCHOOL:

The parent/guardian will immediately be notified at (phone number): _____

Other contact if unable to reach the above parent/guardian (phone number): _____

Other procedures to follow: _____

_____

BLEEDING OR DRAINAGE IS COMING FROM THE TUBE SITE (STOMA):

1. Contact parent/guardian listed above for large amounts of bleeding or drainage from the site. Other contact will be used if unable to reach parent/guardian.

Other procedures to follow: _____

_____

A CLAMP, TUBE, OR CAP TO THE BUTTON COMES OPEN:

1. Will recap or re-secure clamp.
2. Will cleanse the site and change stoma dressing if soiled.

Other procedures to follow: _____

_____

IF STUDENT COUGHS/VOMITS DURING FEEDING:

1. Will stop the feeding.
2. Will estimate the amount of feeding not administered and/or vomited.
3. Contact parent/guardian listed above before re-starting any feedings. Other contact will be used if unable to reach parent/guardian.

Other procedures to follow: _____

_____

TUBING SEEMS TO BE OR BECOMES BLOCKED DURING FEEDING:

1. Will stop the feeding.
2. Contact parent/guardian listed above before re-starting any feedings. Other contact will be used if unable to reach parent/guardian.

Other procedures to follow: _____

_____

STUDENT EXHIBITS GAGGING, NAUSEA, OR ABDOMINAL CRAMPING:

1. For bolus feedings, slow down the rate of feeding and observe. If no vomiting or other signs of cramping, continue feeding at a slower rate.
2. For feeding via pump, stop the pump.
3. If vomiting, stop the feeding.
4. Contact parent/guardian listed above before re-starting any feedings. Other contact will be used if unable to reach parent/guardian.

Other procedures to follow: _____

_____

(Parent and Physician signatures required below)

Parent Signature: _____ **Phone:** _____ **Date:** _____

Physician Signature: _____ **Phone:** _____ **Date:** _____