Beavercreek City School District
Physician's Order Form
Gastrostomy Tube Feedings/Procedures

This form is to provide medical and parental authorization for gastrostomy tube (G-Tube) feeding/ treatments to be provided during school hours. Both physician/provider and parent/legal guardian portions of this authorization from must be completed in its entirety, signed, and return to the school nurse before the treatment(s) may be administered.

Student Name _____ **Date of Birth** _____

School _____ **Grade** _____ **School Year**_____

Physician/Provider Portion

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment(s), which is necessary to be given at school. I am aware that this prescribed service may be administered by non-medical trained staff (though trained by qualified individuals to delegate).

Treatments during school hours: ☐ Feedings ☐ Medication

Type of gastrostomy appliance: ☐ PEG ☐ Button (with or without balloon) ☐ GJ-Tube ☐ Other (describe):

Tube feeding method: ☐ Gravity ☐ Pump (describe pump type and rate/flow settings):

Feeding type: _____ Amount per feed: _____ (cc's) Duration of feeding time: _____ (min)

Frequency of feeds during school day (or specific times): _____

Position: ☐ Sitting upright or semi-reclining with head at ____ degree angle **–OR–**
☐ Lying on right side with head elevated at ____ degree angle **–AND–**
☐ Remain elevated for ____ minutes after feeding administered.

Flushing: ☐ I DO NOT order for G-tube to be flushed
☐ Flush before feeding or medications with _____cc's of free water
☐ Flush after feeding or medications with _____cc's of free water

Aspirate: ☐ I DO NOT order to check for aspirate
☐ I DO order to check for aspirate
☐ If aspirate is > than _____cc's → ☐ Feed ☐ Do NOT feed
☐ Delay feed for ____ minutes, repeat aspiration
If aspirate continues to be greater than _____ , contact parent

Directions for dislodged G-Tube: _____

_____

_____

Adjustments in the treatment or discontinuation of the treatment require a written, signed physician's order. Orders must be renewed every school year. Any medications (prescribed or over-the-counter) needed for this procedure requires the District medication authorization form be filled out and signed by provider. All equipment and supplies needed for this procedure must be provided by parent.

Physician's Name _____ Physician NPI # _____

Physician Signature _____ Date: _____

(over)

Parent/Guardian consent for nurse or appropriately trained staff to perform G-Tube feeds/procedures

I authorize the school nurse to perform G-Tube feeds/procedures of my child while in attendance at Beavercreek City Schools or at Beavercreek City School District events (such as field trips). I understand that school related health services may not be provided for my student without my required consent, as outlined herein.

Parent Initials _____

Parent/Guardian Responsibilities

All supplies needed for this, and any procedure, will be provided by me. If medication is prescribed within this plan, the medication is to be furnished by me in the original container, and BROUGHT TO SCHOOL BY AN ADULT. Prescription medication must be labeled by the pharmacy with the name of the patient, health care provider, medication, dosage, and the time of day to be given. I agree to notify the school nurse immediately if there are any changes to the student's status and/or physician orders. I understand medication may be administered by non-licensed trained designated staff members in accordance with state regulations and district policy. I understand that at the end of the school year, an adult must pick up any medication and/or remaining supplies, otherwise it will be discarded.

Parent Initials _____

Parent/Guardian authorization for school staff to communicate health information

I authorize the districts medical professionals (school nurse and/or school administration) to share/obtain my student's health related information with the medical health professional or health care provided identified above to plan, implement or clarify actions necessary in the administration of school related health services such as, but not limited to; emergency care, care for any documented diagnosis, medical treatments as outlined in student's IHP, 504 plan, or IEP for school health care services. I agree to notify the school nurse immediately if there are any changes to the student's status or physician orders. By signing this authorization, I readily acknowledge that the information used or disclosed pursuant to the authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate. Appropriate discretion will always be used, as outlined by HIPPA and FERPA.

Parent Initials _____

Parent/Guardian Name _____

Phone Number _____ Date _____

The aforementioned guidelines are subject to the Americans with Disability Act ("ADA"), 42 U.S.C. § 12101, et seq.; Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 701, et seq.; and the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. § 1400 et seq.