DOWNEY UNIFIED SCHOOL DISTRICT

AUTHORIZATION FOR GASTROSTOMY FEEDING IN SCHOOL

Parent and Physician Authorized Healthcare Provider Authorization

School Year: _____

Pupil:	**DOB/ID:**	**Date:**
School:	**Teacher/Rm:**	**Grade:**
Diagnosis/Physical condition of student:		
What were the indications for this student's gastrostomy placement:		

1. Type of feeding device

☐ Gastrostomy tube - Type: _____ Size:_____

☐ Gastrostomy button - Size:_____

Type:☐ MIC-KEY ☐ BARD Other:

2. Gastrostomy Feeding (School Hours)

☐ 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. DISASTER Feeding Schedule

☐ Same as #2 Above

☐ Additional Time (s) of feeding _____

☐Other: _____

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, call parent to pick up the student. If parent is unable to pick up student within an hour, 911 will be called.

7. Oral feeding/Recommendation

☐ No Restrictions

☐ 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 ☐ Chopped ☐ Ground

☐ Other Recommendations: _____

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:_____

Physician Signature :_____ **Date:** _____

Office Stamp - REQUIRED

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
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** _____