SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

MEDICAL STATEMENT FOR STUDENT REQUIRING TUBE FEEDING

Valid for 1 school year. To be completed and signed ANNUALLY at the start of each school year and updated as needed, by an **Arizona Licensed Physician/Health Care Provider**

Child's Name: _____ Date of Birth: _____
School: _____ Grade: _____

This Tube Feeding Order is valid for the 20_____ - 20_____ school year **OR** Start Date: ___/___/___ to Stop Date: ___/___/___

To Be Completed by an Arizona Licensed Physician/Health Care Provider:

_____ (Physician Initials) I authorize the School Nurse, Health Assistant, Extended Resource Teacher or Health Inclusion Assistant, or other Authorized Designee/Unlicensed Assistive School Personnel, trained by the parent/guardian, to administer tube feeding as outlined below:

Reason for Treatment:		Allergies:	
Method of Infusion	**Time of Administration**	**Solution**	**Route to be Administered**
____ Pump Rate: _____ Volume: _____ ____ Gravity Volume: _____ over _____ Minutes ____ Bolus Volume: _____ over _____ Minutes			____ G-Tube ____ J-Tube

Flush feeding tube with _____ CC of water and disconnect after feeding is complete.

Is the student competent to self-administer feeding/treatment? _____NO _____Yes

Is Additional Oral Feeding Permitted: _____NO _____ YES
If yes, please provide additional instructions regarding Oral Feeding:

Reinsertion of Gastrostomy Device:

Please Note: Sahuarita Schools do NOT have a full time Licensed Nurse available on any individual school campus. Therefore, the Physician or Licensed Healthcare Provider should select on of the following orders for when a gastrostomy tube should be dislodged:

Initial one below:

_____ (Physician Initials) If gastrostomy device is dislodged, notify the parent/guardian for reinsertion of the gastrostomy device.

- While waiting for parent/guardian to reinsert the gastrostomy device, maintain stoma patency by:
  _____

_____ (Physician Initials) I authorize the School Nurse, Health Assistant, Extended Resource Teacher or Health Inclusion Assistant, or other Authorized Designee/Unlicensed Assistive School Personnel, trained by the parent/guardian, to reinsert the gastrostomy device as follows:

- Insert new gastrostomy device size ____ fr & ____ cm
- Utilize water soluble lubricant or water to facilitate reinsertion of device.
- Inflate balloon with directed amount of water.
- If the Unlicensed Assistive Personnel is unable to reinsert the tube, notify the parent/guardian and maintain stoma patency by: _____

Other Additional Instructions:

Dietician Name and Phone Number (if applicable): _____

Arizona Licensed Physician/Healthcare Provider Signature: .

Provider's Printed Name _____ **Phone:** _____

Provider's Signature: _____ **Date:** _____

**Please attach "Authorization to Administer Tube Feedings and Reinsert Dislodged G-Tube or J-Tube Form

SAHUARITA UNIFIED SCHOOL DISTRICT #30

SCHOOL HEALTH SERVICES

AUTHORIZATION TO ADMINISTER TUBE FEEDINGS AND REINSERT DISLODGED G-TUBE or J-TUBE

Valid for 1 school year. To be completed and signed ANNUALLY at the start of each school year and updated as needed, by an **Arizona Licensed Physician/Health Care Provider**

Child's Name:_____ Date of Birth:_____
School: _____ Grade:_____

We, the undersigned parent/guardian and Physician/Licensed Healthcare Provider of (student) _____, request that TUBE FEEDINGS and GASTROSTOMY TUBE CARE be administered during school hours.

This authorization is valid only for the 20_____ - 20_____ school year **OR** Start Date: ___/___/___ to Stop Date: ___/___/___

We understand that this Authorization to Administer Tube Feedings must be completed fully in order for school staff to administer the required treatment and that a new form must be completed at the beginning of each new school year.

- We understand that the parent/guardian is responsible for providing a **CURRENT MEDICAL STATEMENT FOR STUDENT REQUIRING TUBE FEEDINGS AND/OR TUBE FEEDING PHYSICIAN ORDERS AND INSTRUCTIONS,** which must include child's full name, reason for treatment, allergies, method of Infusion with volume to be infused over what period of time, time of administration, solution, route to be administered, flush instructions, whether or not additional oral feeding is permitted, and whether or not the student is competent to self-administer feeding, as well as any additional instructions.
- **We are aware that there is not a school nurse available to administer tube feedings or provide gastrostomy care (including tube re-insertion if permitted by physician orders);** therefore, this treatment/procedure will need to be completed by the School Health Assistant, Extended Resource Teacher, or other Designated Unlicensed Assistive Personnel. We understand that a parent/guardian is responsible for training all individuals who are assigned to complete this treatment/procedure. We understand that the appointed qualified unlicensed assistive personnel who will perform the task will be indirectly supervised with intermittent direct supervision by the school nurse, a licensed professional nurse (RN).
- We understand that the parent/guardian responsible for providing ALL NECESSARY TUBE FEEDING SUPPLIES AND EQUIPMENT, labeled with the students full name. Parent/guardian is responsible for promptly replacing any supplies prior to expiration date.
- We understand the parents/guardian is responsible for notifying the child's physician that the treatment/procedure will be completed by Unlicensed Assistive Personnel.
- We understand that the parent/guardian must notify the school immediately if there are any changes to the child's health status, diet, or physician orders.
- We understand that the parent/guardian must notify the school immediately if the procedure is changed or canceled. We understand any changes must have a physician's signature.
- We understand that, whenever possible, the physician prescribed treatment should be provided before or after school hours. This assures that the student receives maximum educational time.
- We understand that all self-administered physician prescribed treatments must be performed in the school health office or Extended Resource Room unless another location is pre-authorized by the District Nurse.
- We authorize the school contact emergency medical services for my child whenever the need for such services is necessary.

We authorize the School Nurse, Health Assistant, and the following Authorized Designee /Unlicensed Assistive Personnel to complete the specialized physical health care treatment/procedure as listed above:

Additional Designated Unlicensed Assistive Personnel:

_____ _____ _____

Parent/Guardian Signature: _____ Date: _____

Arizona Licensed Physician/Healthcare Provider Signature authorizes the School Nurse, Health Assistant, Extended Resource Teacher, Health Inclusion Assistant, or Authorized Designee perform the above health care tasks as indicated.

Provider's Printed Name _____ Phone: _____

Provider's Signature: _____ Date: _____

**Please attach "Medical Statement for Student Requiring Tube Feedings" Form