LONG COUNTY SCHOOL HEALTH SERVICES
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION
FOR GASTROSTOMY TUBE CARE

STUDENT INFORMATION

Student's Name _____ **Date of Birth**_____

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

Any known drug allergies/reactions? □ Yes □ No If yes, please list: _____

PRESCRIBER AUTHORIZATION

(To be completed by licensed healthcare provider)

START DATE: _____ **STOP DATE:** _____

Type Formula	Reason for Taking	Route: Enteral	Amount per feeding: _____ ml.	Frequency/Time(s)

RESIDUAL and FLUSH:

Check residual before **feeding?** Yes □ No □ Notify prescriber if residual is greater than _____ ml? Yes □ No □	Flush **before** formula? Yes □ _____ ml. No □ Flush **after** formula? Yes □ _____ ml. No □	Flush **before** medication administered? Yes □ _____ ml. No □ Flush **after** medication is taken? Yes □ _____ ml. No □

STORAGE: Formula requires refrigeration after opening? Yes □ No □ Syringe/tubing stored in refrigeration? Yes □ No □

Self care is permitted and recommended for this student? *Yes □ No □

*If YES, I hereby affirm that this student has been instructed in the proper self-administration of the prescribed formula.

If" yes, do you recommend equipment, supplies and/or formula be kept "on person" by the student? *Yes □ No □

TYPE TUBE:

Mic-Key Button, Foley, Other:	Lumen size: _____ French	Length: _____cm.	Balloon size: _____ ml.

Is student's stoma considered a mature stoma (At least 6-8 weeks post op)? Yes □ No □ *Date stoma considered mature: _____

- If the gastrostomy button or tube becomes dislodged after this date*, the school nurse, who has received specialized training approved by the Georgia Board of Nursing, will reinsert the gastrostomy tube/button or appropriate sized Foley catheter, tape it into place and contact the parent. The nurse will **NOT** inflate the tube/button or Foley balloon and will **NOT** provide an enteral feeding following reinsertion.
- If the gastrostomy button or tube becomes dislodged before this date*, the school nurse will immediately call the parent and prescriber. The parent or guardian will be responsible to pick up the student. The nurse will **NOT** attempt to reinsert the button. If bleeding from the stoma site, difficulty breathing or any change in status occurs 911 will be called immediately.

Treatment Order (Site Care, Dressing Change) : _____

(Attach additional sheet or use the back of this form if necessary)

_____

Printed Name of Licensed Healthcare Provider

Signature of Prescriber	Date	Phone	Fax
_____	_____	_____	_____

PARENT AUTHORIZATION

I authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the procedure. I understand that additional parent/prescriber signed statements will be necessary if the procedure is changed. I also authorize the School Nurse to talk with the licensed healthcare provider should a question come up about the procedure.

Procedure equipment and/or supplies must be registered with the school nurse, principal, or his/her designee. Formula must be in the original, unopened, sealed container and be properly labeled with the student's name.

Signature of Parent	Date	Phone	Cell
_____	_____	_____	_____

SELF-CARE AUTHORIZATION

(To be completed **only** if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-care by my child for the above procedure. *I also affirm that he/she has been instructed in the proper self-care of the prescribed procedure by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-care of prescribed procedure(s).*

Signature of Parent	Date	Phone	Cell
_____	_____	_____	_____