CALEDONIA COMMUNITY SCHOOLS

Treatment Authorization Form- Feeding Tubes

Student Name:_____ Birth Date:_____ School Year:_____

Diagnosis/Condition:_____

Authorization for administration of health treatment and/or medication at school.

- This authorization is only valid for the current school year beginning _____ and ending _____. An authorization form must be completed at the beginning of each school year, for each treatment, and each time there is a change in treatment orders.
- Parents are urged to provide health treatments at home and on a schedule other than school hours, if possible.
- Tube feedings, or medications prescribed for administration through a feeding tube, must be in the original container labeled by the pharmacist or prescriber.
- Non-prescription feedings or medications must be in the original container with the factory label intact.
- Any medical supplies needed to carry out the following treatment must be provided by the parent/guardian.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Health Care Provider Instructions

Feeding Tube Type:

☐ Gastrostomy Tube ☐ Gastrostomy and Jejunostomy Tube ☐ Jejunostomy Tube

Instructions for Administration of Feedings and/or Medications via

☐ Gastrostomy ☐ Jejunostomy

☐ Position student upright or semi-reclining with head at least _____degrees during feeding AND/OR

☐ Keep student upright for _____minutes after feeding

☐Feed: _____ _____

Name of Feeding to be Administered Volume to be Fed

☐ Parents/guardians may provide adjustments to feeding/flush/free water amounts within the following parameters. Changes must be provided to school staff in writing.

Frequency:

☐ Continuous:_____ _____

Specify Rate Time(s) Feeding Administered

☐ Intermittent- Gravity Fed over _____ ☐ Intermittent via pump _____

Specify Time Specify Rate

☐ Check for residuals. If residual greater than _____ mL:

☐ Feed ☐ Do not feed- notify parent ☐ Delay feeding for ___ minutes and recheck residual

☐ Other: _____

☐ Administer free water _____ _____

Volume mL Time(s) / Frequency

☐ Flush tube with water ☐ Before feeding or medications with _____mL

☐ After feeding or medications with _____mL

☐ Do not flush tube with water

Additional Instructions:_____

_____

_____

Gastrostomy and/or Jejunostomy Care in School

If gastrostomy tube becomes dislodged:

☐ Nurse or trained school staff may reinsert gastrostomy tube within _____for patency.

If checked, trained school staff may reinsert with direct supervision of an RN Minutes

☐ Re-insert displaced tube ☐ Insert new gastrostomy tube ☐ Insert foley catheter with balloon

☒ Notify parent/guardian immediately

Note: Gastrostomies may NOT be used in school after dislodgement until parents have had tube replaced with placement confirmed according to provider instructions. Nurses may not replace and confirm placement except for special cases, which require administrative approval and additional instructions from the student's provider.

If gastrostomy with jejunostomy or jejunostomy becomes dislodged, tube must be placed by a provider and: ☒ Notify parent/guardian immediately to contact provider

☐ Cover with 4x4 gauze and tape

☐ Nurse or trained school staff may reinsert gastrostomy tube within for patency Minutes

Instructions if gastrostomy or jejunostomy port becomes clogged:

☒ Notify parent/guardian immediately

☐ Administer prescribed enzymatic de-clogging

Agent:_____

Agent & Instructions

"Home remedy" De-clogging substances (i.e. cola) and excessive force are not approved for use in de clogging ports by nurses and trained school staff.

Additional Gastrostomy and/or Jejunostomy Instructions (i.e. dressings):

_____

_____

_____

Note to Prescriber: *Please consider ordering additional supplies and medications to be kept at school (i.e. tubing, syringes, replacement tubes, etc.)*

Prescriber's Printed Name/Title_____ Prescriber's Signature_____

_____ _____ _____

Date Telephone Fax

Parent/Guardian Authorization

I/we request designated school personnel to provide the treatments in this document as prescribed by the above. I/we certify that I/we have legal authority to consent to medical treatment for the student named above. I/we understand that at the end of the school year, an adult must pick-up any medications and medical supplies, otherwise they will be discarded. I/we authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent Signature:_____ Date:_____

Daytime Contact Number:_____ Fax:_____

Order/Authorization Reviewed by School RN: _____

_____

Signature Date

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Adapted from Michigan Department of Education Administration of Medication in Schools Model School Nurse Guideline (2014)