School Year: _____

In the pursuit of excellence… ..

Caledonia Community Schools

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for a Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse at your school.

- **Student Health Information Sheet**
- **Physician Order for G-Tube Procedure & Parent/Guardian Statement**

We are looking forward to a great year with your student!

STUDENT HEALTH INFORMATION SHEET

School Year: _____

MEDICAL CONDITION: _____

(This form will be made available to teachers and appropriate school staff.)

Place Student's Picture Here

Student's Name: _____ **DOB:**____ / ____ / ____

Allergies: _____

School: _____ Teacher: _____ Grade: _____

Bus Rider: ☐ Yes ☐ No Bus #: AM _____ PM _____ Non-Transported ☐

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Alternate contact person in case of emergency:

Name: _____ Relationship: _____ Phone: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

HISTORY OF MEDICAL CONDITION - Include date of onset and most recent concerns: _____

_____

_____

* MEDICATIONS & TREATMENTS AT SCHOOL: _____

_____

_____

ADDITIONAL COMMENTS: _____

_____

_____

DATE COMPLETED: ____ / ____ / ____ COMPLETED BY: _____

* *Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

REVIEWED BY: _____***, RN*** ***DATE:*** _____ / _____ / _____

School: _____ School Year: _____

PHYSICIAN ORDER FOR G-TUBE FEEDING PROCEDURE

To be completed by the student's Physician and returned to School.

STUDENT'S NAME: _____ **DOB:** _____

ALLERGIES: _____

THE TREATMENTS NEEDED DURING SCHOOL HOURS ARE (please indicate):

☐ **Feeding by gravity** ☐ **Feeding by pump**

☐ **G-tube medications – Please list drug, dosage and frequency:** _____

_____

PROCEDURE FOR FEEDING ADMINISTRATION:

1. POSITION STUDENT

☐ **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 is administered.**

2. ASPIRATE - Check one:

☐ **I DO order to check for aspirate**

If aspirate is greater than _____ cc, ☐ **Feed** ☐ **DO NOT feed**

___ Delay feeding for ( ) minutes, and repeat aspiration.

*****If aspirate continues to be greater than _____ , contact parent.**

☐ **I DO NOT order to check for aspirate.**

3. **FLUSHING – Check one:**

☐ **I DO order G-tube to be flushed** ☐ **Before feeding or medication with _____cc of free water.**

☐ **After feeding or medications with _____ cc of free water.**

☐ **I DO NOT order G-tube to be flushed**

4. **PLEASE SPECIFY DIET That will be given during school day:**

TYPE OF FEEDING: _____ **Amount:** _____

Frequency of feedings during school day: _____

*****Please give _____ of free water at (indicate time) _____AM and/or _____PM.**

5. **COMMENTS:** _____

_____

X _____ _____

(Physician's Signature) Date

_____ _____

(Physician's Name - Printed) Telephone Number

* ***PLEASE NOTE: A Nurse is NOT always in the school building and trains non-medical staff to administer medication and G-tube feedings.***

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of _____, hereby request the School Nurse or trained staff member to administer the above procedure(s) and medication(s) according to the Physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

I agree to notify the School immediately if there is any change in the student's status or Physician's orders.

Parent/Guardian Signature:_____ **Date:** ____ / ____ / ____

Home Phone:_____ **Work:**_____ **Cell:** _____

****

Reviewed by: _____ ***RN*** ***Date:*** _____