Killeen Independent School District
Health Services

Authorized Healthcare Provider Authorization for Management of Gastrostomy at School

Student Name:	**DOB:**	**Grade:**

1. **Type of feeding device**
   ☐ Gastrostomy tube—Type:
   Size: _____ Adjusted tube length:
   ☐ Gastrostomy button
   ☐ MIC-KEY ☐ BARD ☐ Other:
   Size:

2. **Gastrostomy Feeding**
- 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. **Residual**
   ☐ Check residual ☐ Residual check not necessary
   ☐ Feed if residual <
   ☐ Hold feeding if residual >
   Additional instructions:

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 site and notify parent
   ☐ Reinsert gastrostomy tube by RN/LVN
   ☐ Reinsert skin-level button by RN/LVN
   ☐ Unlicensed trained school staff may follow procedure using catheter to maintain temporary ostomy patency.
   ☐ Other:
   Reinsertion must occur within:

7. **Fundoplication:** ☐ No ☐ Yes; date:

8. **Oral feedings**
   Feeding evaluation: ☐ Yes (copy attached) ☐ No
   ☐ 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 foods (i.e. applesauce)
   ☐ Other: _____

9. **☐ Other pertinent information/ recommendations signed and attached to the authorization form.**

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 an 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 made, I will provide new written authorization. Authorizations may be faxed.

***Authorized Healthcare Provider Name** _____**Signature** _____

Date_____ **Phone** _____ **Address** _____**City** _____**Zip** _____

***Nurse Practitioner, Nurse Midwife, Physician Assistant: Furnishing Number** _____

Supervising Physician Name _____ **Address** _____ **Phone** _____

☐ I request that the school nurse provide me with a copy of the completed Individualized Healthcare Plan (IHP).

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 a child's health status or attending authorized healthcare provider; and
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** _____

Reviewed by school nurse (signature) _____**Date** _____

☐ School nurse has informed principal about healthcare services provided for this pupil.