Spring Branch Independent School District

HEALTH SERVICES

## Physician’s Statement for School Gastrostomy Feeding

School Year: \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_

HR Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This Section To Be Completed by Licensed Healthcare Professional:**

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is student NPO? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fluid permitted? (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food permitted? (type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrostomy Device: \_\_\_\_\_\_\_\_Button \_\_\_\_\_\_\_\_ G-Tube \_\_\_\_\_\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding Method: \_\_\_\_\_\_ Syringe \_\_\_\_\_\_Gravity Drip/Bag \_\_\_\_\_ Mechanical Pump (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeding Position: \_\_\_\_\_\_Sitting

 \_\_\_\_\_\_ Supine with head elevated

 \_\_\_\_\_\_ Side-lying on right with head elevated

 \_\_\_\_\_\_ Side-lying on the left with head elevated

 \_\_\_\_\_\_ Prone on wedge with head elevated and to one side

Measure residual stomach contents? \_\_\_\_\_\_ Yes \_\_\_\_\_\_No

*\*If \_\_\_\_\_\_cc total volume, then withhold feeding at that time.*

*\*If student consumes oral feedings, hold tube feeding if student consumes \_\_\_\_\_ 50% of tray \_\_\_\_\_75% of tray \_\_\_\_\_100% of tray*

Name of Formula: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Time | Formula Amount | Water/Flush Amount | Rate |
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Additional Fluids During the Day:

|  |  |  |
| --- | --- | --- |
| Time | Type | Amount |
|  |  |  |
|  |  |  |

Special Instructions: (check all that apply)

 If gagging before or during feeding:

 \_\_\_\_\_ Clamp feeding tube. Attempt feeding in 15-30 min.

 \_\_\_\_\_ Place open syringe in unclamped tube. Hold at the level of student’s head .

 If vomiting after feeding occurs:

 \_\_\_\_\_ Facilitate student’s ability to self-clear mouth through positioning as indicated.

 \_\_\_\_\_ Place open syringe in unclamped tube. Allow stomach contents to drain into container.

 If tube becomes clogged:

 \_\_\_\_\_ Force water into tube, then aspirate. Repeat as necessary.

 \_\_\_\_\_ Move tube gently in and out while rotating position.

 \_\_\_\_\_ Check for tension on tube, move to slightly above the ostomy site.

 If gastrostomy device/tube falls out:

\_\_\_\_\_ To maintain site, wash tube/button with soap and water, place in tract, do not inflate balloon Tape tube/button down and hold all tube/device medications, fluids and feedings. Parent will replace tube.

\_\_\_\_\_ Contact parent, save tube, cover gastrostomy site with gauze. Parent will replace tube.

***\*In order to keep this child in optimum health and to help maintain school performance, it is necessary that this procedure be administered during school hours.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Licensed Healthcare Professional’s Name (print) Licensed Healthcare Professional’s signature**

 **Parent/Guardian Authorization**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ I request that the gastrostomy feeding procedure as prescribed by the physician be administered at school.

\_\_\_\_\_\_ I understand that it is the parent’s responsibility to provide all necessary supplies and equipment as ordered by the physician.

\_\_\_\_\_\_ I understand that it is my responsibility to notify the school if and when these orders change. Unless otherwise specified, this order is good for the current school year and must be renewed each school year.

\_\_\_\_\_\_ My signature below indicates that I am giving permission for SBISD staff to contact the physician for additional information concerning gastrostomy feeding if needed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian Date Phone Number Email address

Preferred method of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

------------------------------------------------------------------------For Office Use Only------------------------------------------------------------------------

The substitute nurse will complete the following checklist during administration of this procedure:

1. Verify student ID—compare with name on this record and on equipment/supplies.
2. Compare name of formula on record with container.
3. Compare the dosage on this record with dosage on container.
4. Prepare the dosage and administer to child. (Note: *Do not set up before student’s arrival*.)

**Record of GI Feeding by Substitute Nurse or Trained Unlicensed Personnel Designee**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date | Time | Stomach Residual (cc’s) | Formula: Amount Given | Flush: Amount Given | Initials |
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**Substitute Nurse or Trained Unlicensed Personnel Designee Signature:**

**(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Initials Signature Initials Signature Initials Signature

**(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Initials Signature Initials Signature Initials Signature

R: 11/21 (ch)