G-Tube Feeding
Individualized Gastrostomy Tube Action and Nursing Care Plan
for _______ School Year

This section to be completed by parent

Student’s Name_________________ DOB ______ Age______
School ___________________ Grade______ HR Teacher__________
Significant Medical History and Reason for feeding tube: ____________________________
__________________________________________________________________________
Allergies______________________________________________
Treating Physician______________ Phone_______ Fax___________

This section to be completed by Physician

Type of gastrostomy tube: _________ Size: ______ Date of placement: ______________
Change or replace feeding tube every _____________ □ PRN
If a G/J tube, which port is used for medications? _________________
Which port is used for feedings? _________________
What action should be taken if the tube comes out? ________________________________
Current Medications: __________________________________________________________
__________________________________________________________________________
Method of feeding: □ Feeding pump □ Gravity □ Other______________
School feeding times__________________________________________________________
Type of Formula: __________________________ Amount: ______________
□ Flush every _______ with _______ Amount ______________
Site assessment frequency ____________________

SUPPLIES TO BE FURNISHED BY PARENT/GUARDIAN:

✓ FORMULA EXTRA G-TUBE
✓ 60 CC SYRINGES FEEDING PUMP
✓ EXTENSION TUBING FOR BUTTONS FEEDING BAGS

Physician’s Signature: __________________________ Date: ____________
Parent/Guardian Signature: __________________________ Date: ____________
Nurse’s Signature: __________________________ Date: ____________
LEON COUNTY SCHOOLS
AUTHORIZATION FOR MEDICATION OR TREATMENT
(Use one form for each medication. This permission form is valid for the current school year only.)

I hereby certify that it is necessary for my child, __________________________ (first/last name) __________________________ (date of birth), to be given the medication or treatment listed below during the school day, including when she is away from school property on official school business. I hereby authorize the School Board of Leon County, Florida (LCSB), and Florida Department of Health in Leon County (DOHLC) and their officers, employees, contractors and agents to assist my child with medication administration and/or to supervise my child's self-administration of medication(s) as directed by his/her prescribing physician(s). I acknowledge and agree that non-health professionals, trained in medication administration, may assist my child with medication administration.

This form must be signed for all the following: medicines given by mouth, inhaled, by nebulizer, on skin, patch, injection, etc. Only FDA-approved prescribed and over-the-counter medicines will be accepted.

Name of medication:_____________________________________________________

Reason for medication (diagnosis):________________________________________

Dosage to be given: __________________________ Route (mouth, injection, etc.): __________________________

Time(s) of administration: _____________________________________________

Allergies: __________________________

Beginning date: __________________________ Ending Date: __________________________

Amount of liquid or count of pills: __________________________

Emergency telephone numbers:

Parent/Guardian: __________________________ H: __________________________ C: __________________________

Parent/Guardian: __________________________ H: __________________________ C: __________________________

Doctor's Name: __________________________ Doctor's Phone Number: __________________________

Prescription and over-the-counter medications/treatments shall come in original, labeled containers. Changes in medication times or dosage can only be made by written prescription from the physician, which may be faxed/scanned to school health personnel. Over-the-counter drugs/treatments shall only be administered up to five calendar days without a signed a licensed prescriber statement. A licensed prescriber must provide signed authorization for a student to self-carry or self-administer medications/treatments allowed by statute 1002.20 and LCSB policy (see back of form).

Parents are responsible for safe delivery of medication to the school (students may not transport medication unless authorized to self-carry emergency medications) and for picking up any leftover medication within ONE WEEK after the ending date. Medication left after this time will be discarded according to LCSB policy.

I hereby consent for the Leon County School District to disclose protected health information, as needed, to provide health services to my child. I understand this health information may be shared with the health care provider listed above, and I hereby authorize the exchange of this information. I also give permission for the information on this form to be utilized by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

I hereby release, indemnify, and hold harmless LCSB, DOHLC and any of their officers, employees, contractors and agents any and all lawsuits, claims, demands, expenses, and actions against them associated with their activities assisting my child with medication administration and/or supervising my child's self-administration of medication(s), provided they follow the physician's orders on record. I also hereby agree to indemnify and hold LCSB, DOHLC and their officers, employees, contractors and agents harmless from any and all lawsuits, claims, demands, expenses, and actions against them arising from harm to any person caused by my child's actions with regards to a self-carried medication.

Date __________________________ Parent/Guardian Signature __________________________
Florida Department of Health in Leon County
CONSENT FOR SHARING OF PROTECTED HEALTH INFORMATION

Student’s Name: __________________________
DOB: __________________________
School: __________________________

School Year _________

I hereby consent to health information being shared to carry out treatment or clarify medical orders in order to keep my child safe while at school. I understand that Registered Nurses from the Florida Department of Health in Leon County, School Health Division, may be giving and receiving information pertaining to the management of my child’s medical condition with the following organizations:

(Please check and initial all that apply)

___ [X] Leon County School District
___ [ ] Tallahassee Memorial Hospital Diabetes Center
___ [ ] Children’s Medical Services
   (Name of case manager: __________________________)
___ [X] Florida Department of Health in Leon County (Health Department)
___ [ ] Tallahassee Pediatric Foundation

___ [ ] Primary Physician
   (Please fill in Physician name)
___ [ ] Specialist Physician
   (Please fill in Physician name)

I may request a notice of the complete description of such uses and disclosures prior to signing this consent.

I understand that I have the right to revoke this consent in writing.

________________________________________  __________________________
Signature   Date