CENTRAL VALLEY
SCHOOL DISTRICT #356

AUTHORIZATION FOR GASTROSTOMY TREATMENT

Student Name:_____ Birthdate:_____ School:_____ Grade: _____

To Be Completed by a Licensed Health Care Provider (HCP)

Indicate Type of Gastrostomy Tube: _____

Treatment Schedule: _____

Reason for Treatment: _____

Instructions: (This section must be completed): _____

_____

Check for residual before bolus feedings?	☐ YES ☐ NO	If YES, return residual if less then _____ ml
Flush with water after each bolus feeding?	☐ YES ☐ NO	Amount: _____ ml
If G-Tube is displaced at school: *(Check appropriate box)*	☐ Parent and/or legal guardian has been trained to replace G-Tube ☐ Child must see their doctor or surgeon for reinsertion of the g-tube. ☐ Other _____	

****Medications to be given at school require completion of an *Authorization for Medications* form.**

I request and authorize that the above named student be provided the above identified treatment in accordance with the instructions indicated above for the period commencing with the _____ day of_____, 20 _____ through the ____day of _____ , 20 ___ as there exists a valid health reason which makes provision of the treatment advisable during school hours or during such time that the student is under the supervision of school officials. Such treatment may be administered by school personnel who have no formal medical education.

_____ Signature: _____

Date of Signature (Licensed Health Care Provider)

Telephone: _____ Name: _____

(Print or Type)

To Be Completed by the Parent or Legal Guardian

G-Tubes that become dislodged or fall out: Please be aware that school staff does not have universal training to replace G-tubes. It is the responsibility of the parent and Health Care Provider to plan for safe replacement during the school day or school activities. Please refer to Emergency Care Plan for more information about Central Valley School District G-Tube Replacement Plan. Central Valley School District will not be responsible for replacing a gastrostomy tube.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed. Procedure might be delayed or missed due to unexpected circumstances or changes in the student's schedule.
- I agree to hold Central Valley School District harmless from any liabilities that may occur in rendering this service except as might arise because of negligence on the part of its employees.
- **I understand that I must provide all necessary supplies and equipment to perform this service.**

I certify that I am the parent, legal guardian, or other person in legal control of the above identified student and request and authorize the school to provide treatment to the above identified student in accordance with the prescriptive authority's instructions for the period commencing with the _____ day of _____, 20____. I understand and agree that because of schedule and other responsibilities, treatments may be delayed or missed.

Date of Signature: _____ Signature: _____ Telephone Number(s): _____