Request for Individualized Health Care Procedures in School

GASTROSTOMY

Student: _____ Grade: _____

School: _____ School Year: _____

Reason for the g – tube: _____

Type of g – tube:

_____ Button _____ Catheter _____ Other

Will g – tube feedings be given at school? _____ Yes _____ No

Name of formula: _____

Time(s) for feedings: _____

Feeding to be given: _____ cc over _____ minutes

Feedings to be administered by: _____ pump

_____ gravity

Volume of water to follow feeding: _____ cc

Is this student able to have any food by mouth? _____ yes _____ no

If yes, please describe type and volume: _____

_____

Note to Health Care Provider/Parent/Guardian:

* Formula must be sent to school in the original unopened container along with any necessary feeding supplies.
* The parent/guardian will be notified if the g – tube becomes clogged or dislodged.
* Classroom personnel cannot forcefully flush or replace a tube into the stomach.

Physician Signature: _____ **Date:** _____

Please Print: **Physicians Name:** _____

Address: _____

Phone: _____ **Fax:** _____

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