Jefferson County Public Schools Health Services *JCPS Student ID#:*_____

Primary Care Provider (PCP) Authorization: G-Tube/Swallowing/Feeding Disorders (Side One)

2014-2015 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

***Diagnosis:** _____

Type of G-tube

☐ Button ☐ Catheter

Name of formula: _____

***Feeding formula must be sent to school in the original unopened container.**

Pump to be used: ☐ Yes ☐ No

☐ Type of pump: _____

☐ Flow rate _____cc/hour

Gravity: ☐ Yes ☐ No

Volume to be given: _____oz

Volume of water to follow feeding: _____ cc

Positions:

During feeding: _____ After feeding: _____

Feeding time(s): _____ _____ _____ _____

May additional water be administered for outdoor field trips during warm weather? ☐ Yes ☐ No Amount _____

If G-tube becomes dislodged can a trained Nurse replace it?

☐ Yes ☐ No

Additional Health Care Provider's Comments: _____

_____

_____

Please Complete Both Sides of Form. Form MUST be Signed by Health Care Provider and Parent/Guardian

***Latex Allergy:** ☐ YES ☐ NO

SWALLOWING & FEEDING DISORDERS

Is child allowed to have any food/drink by mouth?

☐ Yes ☐ No

HAS CHILD HAD A SWALLOW TEST IN THE LAST TWO (2) YEARS?

☐ Yes ☐ No

IF YES, PLEASE ATTACH COPY OF MOST RECENT SWALLOW TEST.

1. Does this student have a disability? ☐ Yes ☐ No,

If Yes, Describe the major life activities affected by the disability: ___

_____

2. Does this student have special nutritional/feeding needs?

☐ Yes ☐ No

If Yes, Describe: _____

3. List any medical dietary restrictions, special diet, and/or life threatening food allergies. _____

***** Please note if life threatening food allergies then an Asthma/ Food Allergies PCP form needs to be completed.*****

NUTRITIONAL SERVICES CANNOT PROVIDE A DIET MODIFICATION WITHOUT PRIMARY CARE PROVIDER DIRECTIONS

4. List foods that need textural modification (If all foods need to be prepared in this manner indicate "ALL")

☐ Cut up or chopped into bite size pieces: _____

☐ Finely ground: _____

☐ Pureed: _____

☐ Other Specifications: _____

5. Feeding/Oral Motor Recommendations: _____

6. Feeding Equipment: _____

7. Positioning for Feeding/Eating: _____

	Initials/Date
Reviewed by Health Services	_____
Entered by Heath Services	_____
School Received/Sent to Health Services & School Staff	_____

Jefferson County Public Schools Health Services *JCPS Student ID#:*_____

Primary Care Provider (PCP) Authorization: G-Tube/Swallowing/Feeding Disorders (Side Two)

2014-2015 School Year

Student Name: _____ **Date of Birth:** _____ **School:** _____

EMERGENCY PLAN OF ACTION

1. If breathing stops or other signs of distress: Call EMS 911.
2. Notify school personnel trained in CPR/first aid respond and initiate CPR if needed prior to EMS arrival.
3. Notify parent/guardian or emergency contact immediately.
4. School personnel cannot forcefully flush or replace a tube into the stomach. However, a trained nurse (APRN, RN, or LPN), if available may replace tube. If nurse is unavailable or no replacement g-tube is available, then school staff will place gauze and tape over the site if tube becomes dislodged.
5. The parent/guardian will be notified immediately if a tube becomes **clogged or dislodged**. If unable to reach the parent/guardian within 30 minutes of tube becoming dislodged AND/OR they are unable to get to school within 1 hour of tube becoming dislodged, **call EMS 911.**
6. If EMS is called the student must be transported via EMS to emergency facility, or parent/guardian must sign release with EMS and then parent/guardian assumes responsibility for student. The student may not return to school that day.
7. When student is transported via EMS, JCPS staff must ride with student unless parent and/or emergency contact accompanies them.
8. **If student requires medical treatment while on the bus, the driver will contact EMS.**
9. Other (Specify): _____

Form must be signed by health care provider and parent/guardian. If you have any questions please call (502) 485-3387 or Fax: (502) 485-3670.

Please return to: Jefferson County Public Schools, Health Services, Lam Building, 4309 Bishop Lane, Louisville, KY 40218

_____ _____

Printed Name of MD, APRN, or PA Telephone No.

_____ _____ _____

Signature of MD, APRN, or PA Address Date

Note to parent/guardian: Signing this form shall release the Jefferson County Board of Education and its employees from liability of any nature that might result from this plan of action. This form shall not relieve the liability of the school or its employees for their own negligence. Also, I hereby give permission for the healthcare provider completing and signing this form to verify this information with JCPS and to consult with JCPS staff regarding this information. I also acknowledge that feedings and the emergency plan of action will most likely be administered by trained, unlicensed JCPS personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip these medications and/or health services may also be provided by a licensed volunteer.

_____ _____ _____

Signature of Parent/Guardian Telephone No. Date

****Parent/Guardian signature required only for INITIAL 2014-2015 PCP form. Parent/Guardian signature not required for updated 2014-2015 PCP forms.**

_____ _____ _____

Emergency Contact Telephone No. Relationship

Final 4/21/2014