Wayne County Schools Health Services

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

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: _____

Wayne County Schools Health Services

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

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

EMERGENCY PLAN OF ACTION

1. If breathing stops or other signs of distress: Call EMS 9-911.
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 9-911.**
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, WCS 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 (606) 348-8484.

_____	_____	_____
Printed Name of MD, APRN, or PA	Address	Telephone No.
_____	_____	_____
Signature of MD, APRN, or PA	Fax No.	Date

Note to parent/guardian: Signing this form shall release the Wayne 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 WCS and to consult with WCS staff regarding this information. I also acknowledge that feedings and the emergency plan of action will most likely be administered by trained, unlicensed WCS personnel.

_____	_____	_____
Signature of Parent/Guardian	Telephone No.	Date
_____	_____	_____
Emergency Contact	Telephone No.	Relationship