Jefferson County Public Schools Health Services

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

2011-2012 School Year

Student Name: ______________________ **Date of Birth:** ________________ **School:** ______________________________

***Diagnosis:** ____

<u>**Type of G-tube**</u>

☐ 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

<u>**SWALLOWING & FEEDING DISORDERS**</u>

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 Health Services	___________
School received/sent to Health Services	___________

Jefferson County Public Schools Health Services

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

2011-2012 School Year

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, 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	____________________ Address	______________________________ Telephone No.
______________________ Signature of MD, APRN, or PA	____________________ Fax No.	______________ 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.

______________________________ Signature of Parent/Guardian	________________ Telephone No.	___________________ Date

****Parent/Guardian signature required only for INITIAL 2011-2012 PCP form. Parent/Guardian signature not required for updated 2011-2012 PCP forms.**

________________________________ Emergency Contact	__________________ Telephone No.	____________________ Relationship

Final April 4, 2011