Phoenix Union High School District

GASTRIC TUBE HEALTH CARE ACTION PLAN AND PHYSICIAN ORDERS
TUBO GASTRICO PLAN DE ACCION SANITARIA Y PEDIDOS MÉDICOS

School Year (Año Escolar): _____ Grade (Grado): _____ Date of Birth (Fecha de Nacimiento): _____

Student Name (Nombre de Alumno): _____ Student ID #: _____

Parent/Guardian Name (Nombre de Padre/Madre/Tutor): _____

Cell Phone (Teléfono Cellular): _____ Work (Trabajo): _____ Home (Casa): _____

Physician (Nombre del Medico): _____ Phone (Teléfono): _____

The parent/guardian agree and understand that they are responsible for maintenance of equipment, furnishing all equipment, medications, and supplies necessary in providing services to the student during school hours. The parent/guardian is also responsible for notifying the school nurse anytime there is a change in orders, medications, and/or in the student's medical condition.

I give permission for the school to allow authorized trained school personnel to administer medications and perform medical procedures as ordered by the physician/healthcare provider licensed in Arizona. I authorize the school to contact my child's physician/healthcare providers and/or dispensing pharmacies, should any questions, any additional orders and/or necessary documents be required for the care of my child during school hours.

El padre / tutor acuerda y entiende que es responsable del mantenimiento del equipo, el suministro de todo el equipo, los medicamentos y los suministros necesarios para proporcionar servicios al alumno durante el horario escolar. El padre / tutor también es responsable de notificar a la enfermera de la escuela cada vez que haya un cambio en las órdenes, medicamentos y / o en la condición médica del estudiante.

Doy permiso para que la escuela permita que el personal autorizado de la escuela capacitada administre medicamentos y realice procedimientos médicos según lo ordenado por el médico o proveedor de servicios de salud con licencia en Arizona. Autorizo a la escuela a ponerse en contacto con el médico de mi hijo / proveedores de atención médica y / o farmacias de entrega, en caso de tener preguntas, pedidos adicionales y / o documentos necesarios para el cuidado de mi hijo durante el horario escolar.

_____ _____

Parent/Guardian Signature (Firma de Padre/Madre/Tutor) Date (Fecha)

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FOR LICENSED PHYSICIAN/HEALTHCARE PROVIDER USE ONLY - PLEASE WRITE LEGIBLY

THE PHOENIX UNION HIGH SCHOOL DISTRICT IS REQUESTING YOUR ASSISTANCE IN COMPLETING THIS TWO-PAGE FORM TO IDENTIFY ANY SERVICES THAT WE MAY NEED TO PROVIDE TO THE STUDENT IN THE SCHOOL SETTING.

State laws require written permission from the parent/guardian and written orders from the physician/healthcare provider licensed in Arizona prior to allowing authorized trained school personnel to perform medical procedures and/or administration of prescribed medications during school hours. Prescribed and emergency rescue medications must be packaged in the original labeled container prepared by the pharmacy (i.e., no envelopes, foil, baggies, or any other containers) and the dispensing label must have the name of the student, name of the medication, dosage, route, and time to be administered. OTC medications (including vitamins) must be brought to school by the parent/guardian in the original container with all warnings and directions intact.

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Student Name: _____ School Year: _____

STUDENT MEDICAL DIAGNOSIS:_____

_____

Please include brand type of gastric tube, size of tube (Fr), length, type, balloon/non-balloon, and if balloon is present, amount of water ml instilled in the balloon:

_____

_____

Phoenix Union High School District DOES NOT allow the re-insertion of gastric tubes, the parent/guardian will be notified immediately of situation by school personnel and child must be picked up within 2 hours from the school for evaluation and treatment to be done by a physician/healthcare provider. EMS 911 will be called for emergent situations as needed.

FORMULA ADMINISTRATION AND PHYSICIAN ORDERS ☐ **SEE MEDICAL DOCUMENTS/ORDERS ATTACHED**

Type of Formula:_____

Amount of feeding solution to be given: _____ml ☐ I DO NOT order for aspiration to be performed
Time to be fed during school hours: _____ am/pm _____ am/pm _____ am/pm _____ am/pm
☐ Pump feedings; please provide at a rate of _____ ml/hour Type of Pump: _____
☐ Feeding by gravity as needed
☐ Sitting upright or semi-reclining with head elevated; remain upright after feeding for _____ minutes
☐ I DO order for the gastric tube to be flushed with the following instructions:

- ☐ Before feeding with _____ ml of free water ☐ After feeding with _____ ml of free water
- ☐ Before medication with _____ ml of free water ☐ After medication with _____ ml of free water

MEDICATION ADMINISTRATION AND PHYSICIAN ORDERS ☐ **SEE MEDICAL DOCUMENTS/ORDERS ATTACHED**

Must include name of medication, dose, route, administration time, or as needed. Medications brought to the school by the parent/guardian must be in the original labeled container dispensed by the pharmacy and must include a current pharmacy label with physician instructions and student's name.

_____

_____

PHYSICIAN OR HEALTHCARE PROVIDER SIGNATURE REQUIRED BY THE SCHOOL

A school nurse is NOT always available on the school campus, but trains authorized unlicensed assisted personnel (UAP) to care and manage gastric tubes, administer medications as ordered by the physician/healthcare provider and perform first aid rescue measures as needed.

Physician/Healthcare Provider Printed Name: _____

Physician/ Healthcare Provider Signature: _____ Date: _____

Telephone Number: _____ Fax Number: _____

Reviewed by School Nurse Date: _____ Signature: _____

Revised 4/2/18, 4/12/18, 5/10/18, 8/12/18, 5/4/20
Policy: JLCD Administering Medications to Students