School Year: _____

Lexington-Fayette County Health Department

SCHOOL HEALTH DIVISION
650 Newtown Pike
Lexington, Kentucky 40508-1197
(859) 288-2314
(859) 288-2313 Fax

PARENT PACKET – G-TUBE

Dear Parent/Guardian:

You have informed us that your student has a medical concern. Enclosed are forms, which need to be completed by both the Parent/Guardian and student's Physician. These forms are necessary in order for the School Nurse or appropriately trained school personnel to perform or administer specific medical treatment or procedures. This information will help us work with your student to minimize unnecessary restrictions, feelings of being treated differently, and possibly absenteeism.

Please send a current picture of your student in order for the student to be easily identified. This information will be distributed to appropriate school personnel on a need-to-know basis and may include bus drivers, substitute teachers, cafeteria staff, and others who work with your student daily.

To help your student, please let us know of any changes in your student's medical condition or emergency daytime phone numbers.

The following need to be returned to the School Nurse at your school.

- **Student Health Information Sheet**
- **Physician Order for G-Tube Procedure & Parent/Guardian Statement**

We are looking forward to a great year with your student!

Please call the Health Department's School Health Program at 288-2314 if you have any questions.

STUDENT HEALTH INFORMATION SHEET

School Year: _____

MEDICAL CONDITION: _____

(This form will be made available to teachers and appropriate school staff.)

Place Student's Picture Here

Student's Name: _____ **DOB:** ___/___/ **Allergies:** _____

School: _____ Teacher: _____ Grade: _____

Bus Rider: ☐ Yes ☐ No Bus #: AM_____ PM_____ Non-Transported ☐

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Alternate contact person in case of emergency:

Name: _____ Relationship: _____ Phone: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

HISTORY OF MEDICAL CONDITION - Include date of onset and most recent concerns: _____

_____

_____

* MEDICATIONS & TREATMENTS AT SCHOOL: _____

_____

_____

ADDITIONAL COMMENTS: _____

_____

_____

DATE COMPLETED: ____/____/____ COMPLETED BY: _____

* *Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.*

REVIEWED BY: _____***, RN*** ***DATE:*** _____/_____/ _____

Physician Order and Parent/Guardian Authorization for G-TUBE FEEDING

To be completed by the student's Physician and returned to School Health: Confidential FAX (859) 288-2313 or by mail: Lexington-Fayette County Health Department, School Health Division, 650 Newtown Pike, Lexington, KY 40508

Student Name: _____ **DOB:** _____

Allergies: _____ **G-tube Type:** _____ **Size:** _____

The treatments needed during school hours are (please indicate):

- ☐ Feeding by gravity ☐ Feeding by pump Type of Pump: _____
- ☐ Blended Diet Syringe Bolus
- ☐ G-tube medications – Please list drug, dose and frequency: _____
  _____

Procedure for feeding administration:

1. **Position student**
   - ☐ Sitting upright or semi-reclining with head at _____ degree angle - OR -
   - ☐ Lying on right side with head elevated at _____ degree angle – AND -
   - ☐ Remain elevated for _____ minutes after feeding is administered.

2. **Aspirate - Check one:**
   - ☐ I **DO** order to check for aspirate. If aspirate is greater than _____ ml ☐ Feed ☐ DO NOT feed
     ***Delay feeding for _____ minutes, and repeat aspiration.
     ***If aspirate continues to be greater than _____ml contact parent.
   - ☐ I **DO NOT** order to check for aspirate.

3. **Flushing – Check one:**
   - ☐ I **DO** order G-tube to be flushed ☐ Before feeding or medication with _____ml of free water.
     ☐ After feeding or medications with _____ ml of free water.
   - ☐ I **DO NOT** order G-tube to be flushed

4. **DIET** Student is allowed to eat/drink by mouth: ☐ **Yes** ☐ **No** ***If Foods need to be modified/thickened/pureed, please complete Food Service Modification Form**

   Type of Feeding: _____ **Amount:** _____ **Frequency:** _____
   (Feeding Formula must be sent to school in labeled container with ingredients listed.)

   ***Please give _____ml of free water at (indicate time) _____AM and/or _____PM.**

5. **COMMENTS:** _____
   _____

Parents will be notified immediately if tube becomes dislodged. It is recommended that a replacement tube be kept at school in the event of tube dislodgement and parent is called to replace it. School Staff are not able to replace tube.

X _____ _____
(Physician's Signature) Date

_____ _____
(Physician's Name - Printed) Telephone Number

PARENT/GUARDIAN STATEMENT

☐ I, the undersigned Parent/Guardian of_____, hereby request the School Nurse or trained staff member to administer the above procedure(s) and medication(s) according to the Physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

*****I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders.**

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

Parent/Guardian Name: _____ **Phone:** _____ **Cell:** _____

Reviewed by:_____***RN*** ***Date:*** _____

Fayette County Public Schools

FEEDING PLAN

Student Name_____DOB_____Age_____Grade _____

School_____Teacher _____

Parent(s) _____

Phone (Home)_____(Work)_____(Cell) _____

Primary Physician_____Phone _____

Current Medications: _____

_____

Medical Equipment in use: _____

Precautions/Emergency Procedures related to feeding/swallowing: _____

_____

DIET: ***attach physician's or medical dysphagia team's orders

_____full tube feeding (____G tube_____J tube)
_____full oral feeding
_____mixed oral/tube feeding (describe_____)
_____parent/guardian provides meals/snacks
_____regular school meals/snacks
_____modified school meals/snacks (**FOOD SERVICE MODIFICATIONS** form required)

Food/liquid content/quantity _____

_____

Food/liquid texture (clarify terminology used and preparation method) _____
_____
_____

Feeding schedule _____

SPECIAL EQUIPMENT:

For food preparation _____
For feeding _____
For oral hygiene _____

SEATING

_____regular seating
_____wheelchair_____at table_____tray attached
_____special seating (describe_____)

POSITIONING:

_____independently upright
_____supported upright (how? _____
_____independently reclining (how?_____angle_____)
_____supported reclining (how?_____angle_____)
_____side lying (specify side_____)
_____prone
_____supine
_____other (describe _____

FOOD PRESENTATION

_____bottle_____cup_____straw_____spoon_____fork_____knife_____bowl_____plate Volume of food/liquid per

presentation _____

If child is fed, name and title of feeder(s) _____

_____

Placement of feeder/assistor (location and proximity to child _____

_____

Placement of feeding implements _____

FEEDING PATTERN

Number of swallows per bolus (bite)_____
Provide_____(quantity, type) liquid after
_____(number) of food presentations.

SPECIAL TECHNIQUES

_____head tilting at_____angle_____to left_____to right
_____head turning to_____left_____right
_____chin lift
_____chin tuck
_____holding breath during swallow
_____other (describe) _____

ORAL HYGIENE

_____Independently clears food from mouth
_____Independently brushes teeth/rinses mouth
_____Requires assistance by _____

Tooth brushing schedule _____
_____Has oral prosthesis or braces

Comments:

COPY TO: ☐ School Nurse
☐ Teacher
☐ Cafeteria Manager

Food Service Modification Form

This form must be completed and signed by a Physician if your student requires a dietary restriction.
(i.e. no peanut butter, no strawberries, etc.) **OR a food substitute** (i.e. allergic to cow's milk – substitute soy milk).
This also pertains to other dietary accommodations (i.e. pureed foods, thickened liquid, etc.)
This form must be completed and signed by the student's Physician to ***reverse*** **a previous accommodation** (i.e. "Student no longer restricted on strawberries – Please lift restriction," "Student no longer requires pureed foods – Please lift restriction" etc.)
Once the form is on file, it will remain valid until a new form is presented.

PART A

Name of Student:		**Date of Birth:_____/_____/_____**	
Allergies:		**Is this Allergy Anaphylactic? YES NO**	
Current School:	**Grade:**	**Classroom:**	
Does student have a Disability/Special Need? Describe the major life activities affected. _____		☐ **Yes**	☐ **No**
Does student have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed Physician.		☐ **Yes**	☐ **No**

PART B

List any dietary restrictions/allergies or special diet: _____

Food(s) to OMIT : ☐Fluid Milk ☐Cheese ☐Yogurt ☐Foods/recipes with milk or milk products as an ingredient

☐Whole eggs (scrambled, hard boiled) ☐Food/recipes with any egg listed as an ingredient ☐Wheat/Gluten

☐ Oats ☐Peanuts ☐Tree Nuts ☐Whole corn (corn kernel, tortilla chips, corn muffin, popcorn)

☐NO foods/recipes with corn listed as an ingredient (corn syrup, cornstarch, etc.) ☐ Shellfish ☐Fish

☐Other:_____ **For nutrition/ingredients for FCPS meals: www.fayette.nutrislice.com**

☐ **List any foods to avoid for religious reason** ** ☐ **Pork** ☐ **Gelatin**** *Religious reason does not require Physician Signature*

☐ **Food Intolerance:**_____ ☐ **Avoid Red Dye** ☐ **Avoid Lactose**

List foods to be substituted: _____

☐**NO Substitutes required** **Please Substitute with** ☐ **Lactose Free** ☐ **Soy Free** ☐ **Sun butter**

Texture Modification:

Liquids:
- □ **Thin (Regular liquids)**
- □ **Nectar Thick**
- □ **Honey Thick**
- □ **Pudding Thick**

Solids:
- □ **Large foods cut into bite size**
- □ **Mechanical Soft (chopped)**
- □ **Mechanical Soft (ground)**
- □ **Pureed (Applesauce texture)**

List any special equipment or utensils that are needed:

Indicate any other comments about student's eating or feeding patterns:

Which meals will your student eat from the Cafeteria? ☐**Breakfast** ☐**Lunch** ☐**None** **(will bring from home)**

Parent/Guardian's Signature: _____	**Date:_____/_____/_____**
Physician's Signature: _____	**Date:_____/_____/_____**

REVIEWED BY NURSING: _____ ***RN*** ***DATE:*** _____

ROLES IN THE MANAGEMENT OF STUDENTS WITH A G-TUBE BUTTON

PARENT/GUARDIAN'S RESPONSIBILITIES

- Notify the school of your child's G-Tube/Button prior to the start of the school year OR as soon as possible after G-tube placement.
- Fill out and return ALL forms in the G-tube packet to the school. The packet contains the necessary information to properly care for your child at school and includes such information as Physician's orders and parent/guardian authorization.
- Keep school informed of changes of address and phone numbers, including those of emergency contacts.
- Inform the school and/or School Nurse of changes in the care of your child such as, changes in prescribed formula or medications.
- Provide necessary maintenance, replacement, or reinsertion of G-tube.
- Provide properly labeled formulas and medications and replace medications as needed and upon expiration.
- Provide the school with the supplies needed in order to feed/medicate your child at school, including prescribed formula and/or medications to be given through G-tube during school hours. Supplies may include, but are not limited to: syringe, extension tubing, disposable tubing, clamp for tube, feeding bag, container for water, continuous feeding pump, cleaning materials for supplies.
- Work with the school faculty/staff to develop a plan that accommodates your child's needs throughout the school including in the classroom, in the cafeteria, in after-care programs, during school-sponsored activities, during field trips, and on the school bus.
- Meet with School Nurse and school faculty/staff prior to beginning of school year to discuss feeding/medication administration technique in order ensure care will be performed to the best of ability during school day.

SCHOOL'S RESPONSIBILITY

- Be knowledgeable and follow applicable federal laws including ADA, IDEA, Section 504, and FERPA.
- Review health records of students submitted by parents and physicians.
- Inform School Nurse of names of relevant school faculty/staff that should participate in in-service training for a particular student.
- Be able to include student in all school functions. Student should not be excluded solely based on his/her G-tube/button.
- Coordinate with School Nurse to ensure all prescribed formula and medication is appropriately stored.
- Inform school district transportation department of G-tube so that appropriate training and transportation can occur.
- Discuss field trips with parent/guardian to plan for G-tube care, feeding and/or medication administration.

CLASSROOM TEACHER'S RESPONSIBILITY

- Review health information sheet, Physician orders, and outlined procedures related to student with G-tube.
- Participate in in-service training provided by the School Nurse and parent/guardian of student that addresses needs specific to student.
- Ensure para-educators or other school faculty/staff in your classroom attend in-service training if they will be actively involved in the care or feeding and/or medication administration of a particular student.
- Leave information in an organized, prominent, and accessible format for substitute teachers and other school faculty/staff in your absence. Ensure a trained faculty/staff member is present in your absence to administer necessary care to student.
- Inform School Nurse of any complications or adverse reactions related to feeding and/or medication administration. If School Nurse is unavailable notify parent. In extreme emergencies, such as difficulty breathing, follow parent's instructions found on information sheet. If no instructions are provided, notify EMS first, then parent.

RESPONSIBILITY WITH REGARD TO FIELD TRIPS

- Notify the School Nurse two weeks prior to field trip. Please include date, time, and location.
- Ensure needed formulas, medications, and supplies are brought on field trip.
- Ensure that a functioning cell phone or other communication device is taken on field trip in case of emergency.
- Provide invitation to parent/guardian of student with G-tube to accompany their child on field trips, in addition to being a chaperone. However, the student's attendance must not be conditioned on the presence of a parent/guardian. Parent must comply with Fayette County Public School Policy and have a background check completed prior to field trip.
- At least one, if not two school faculty/staff should be present on field trip to provide care to student, if parent is not available to accompany student.

SCHOOL NURSE'S RESPONSIBILITY

- Provide G-tube packets to parents and provide master copy for office staff.
- Arrange a time for in-service training for school faculty/staff with parent/guardian of student present.
- Train appropriate school faculty/staff during an in-service with parent/guardian of student present.
- Provide health information sheet to school faculty/staff on a need-to-know basis.
- Document school faculty/staff who have been trained.
- Follow-up with trained faculty/staff periodically to assure ordered care is provided to student.

STUDENT'S RESPONSIBILITY

- Be an active participant if medically capable.