*JCPS Student ID#*_____

Jefferson County Public Schools Health Services

PCP Form/School Health Plan: G-Tube/Swallowing/Feeding Disorders (Side One)

School Year: _____

Student Name: _____Date of Birth: _____School: _____

Latex Allergy/Sensitivity**:** ☐ YES ☐ NO

DIAGNOSIS: _____

Type of Feeding Tube

☐NG Tube ☐NJ Tube ☐G Tube ☐J Tube ☐ GJ Tube

☐ Button ☐ Catheter ☐Other:_____

Name of formula: _____
***Feeding formula must be sent to school in a labeled container with ingredients listed.**

Pump to be used: ☐ Yes ☐ No

☐ Flow rate _____mL/hour

Gravity: ☐ Yes ☐ No

Volume to be given: _____mL

Feeding time(s): _____ _____ _____ _____

Volume of water: _____ mL **Water time(s): _____ _____**

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

If Feeding Tube becomes dislodged can a trained Nurse replace it?
☐ Yes ☐ No

Additional Health Care Provider's Comments: _____
_____

Please complete both sides of this form. Form MUST be signed by a Health Care Provider AND parent/guardian.

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. How does the disability restrict the child's diet? _____
_____
3. Which meals provided by the school cafeteria will the student eat by mouth?
☐ Breakfast ☐ Lunch
4. 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.***
5. Please list:
Foods to omit: _____
Foods to substitute: _____

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

6. 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: _____
7. Thickened liquids: ☐ Yes Consistency:_____ ☐ No
8. Feeding/Oral Motor Recommendations: _____
9. Feeding Equipment: _____

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

*JCPS Student ID#*_____

Jefferson County Public Schools Health Services

PCP Form/School Health Plan: G-Tube/Swallowing/Feeding Disorders (Side Two)

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, unless parent/guardian signs release with EMS. Parent/guardian then 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): _____

THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER AND PARENT/GUARDIAN.

_____	_____	_____	_____	_____
Printed Name of MD, APRN, or PA	Signature of MD, APRN, or PA	Address	Telephone #/Fax #	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 #	Date

****Parent/Guardian signature required only for INITIAL health form for current school year.**

Were you charged a separate fee to have this form completed?
☐ Yes ☐ No

_____	_____	_____
Emergency Contact	Telephone #	Relationship

Please return to: Jefferson County Public Schools, Health Services Department, LAM Building
4309 Bishop Lane, Louisville, KY 40218
Telephone # (502) 485-3387 Fax # (502) 485-3670

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REV 4/2018