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

JEFFERSON COUNTY PUBLIC SCHOOLS
SCHOOL HEALTH PLAN
G-Tube

School Year:

DO NOT WRITE IN THIS AREA
8236561988

Please print neatly. Por favor, escriba legible

PART A Parent / Guardian: Complete Items 1 - 11 *(Padre/madre/tutor: complete la información en los espacios 1 al 11)*

1) Student ID# *(Numero de estudiante)* | **2) Student's Last Name** *(Apellido)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

5) School *(Escuela)* | **6) Grade** *(Grado)*

Parent/Guardian Name & Contact Information ***(Nombre & Información del contacto)***

7) Name *(Nombre)* | **8)** Phone Number *(Teléfono)* ( ) - | **9)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

10) Emergency Contact (Contacto de emergencia y Teléfono) ( ) -

11) 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 exchange information with JCPS staff regarding this health condition. 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.
Parents please note: In order for medications to be administered, parent must complete an "Authorization for Medication" form for each medication needed at school.

PARENT/GUARDIAN Signature X | **TELEPHONE NUMBER** ( ) - | **DATE**

PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 24
(12 al 24 - Esta sección para ser completada por el médico solamente.)

12) LATEX ALLERGY/SENSITIVITY: ☐ **YES** ☐ **NO**

13) Student Diagnosis:

14) Type of Feeding Tube
☐ **NG Tube** ☐ **NJ Tube** ☐ **G Tube** ☐ **J Tube** ☐ **GJ Tube** ☐ **Other:**_____

15) Is child allowed to have any food/drink by mouth? ☐ **YES** ☐ **NO**

16) Name of Formula: _____ Volume to be given: _____ml
**Feeding formula must be sent to school in a labeled container with ingredients listed

17) Pump to be used: ☐ **YES** ☐ **NO**

18) Gravity: ☐ **YES** ☐ **NO**

19) Feeding Time(s): _____ _____ _____ _____

20) Additional volume of water: _____ ml Water times: _____ _____

21) May additional water be administered for outdoor field trips during warm water:
☐ **YES** Amount: _____ ml ☐ **NO**

22) If Feeding Tube becomes dislodged can a Trained Nurse replace it? ☐ **YES** ☐ **NO**

23) Additional Health Care Provider's Comments:

_____

_____

_____

24) Healthcare Provider Information Form **must** be signed by a Healthcare Provider **and** parent/guardian

Healthcare Provider Signature X | Date

Healthcare Provider Printed Name

Medical Office Stamp (required for processing)

This institution is an equal opportunity provider and employer.