

Jefferson County Public Schools Health Services

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

2017-2018 School Year

Student Name: _____ Date of Birth: _____ School: _____

Latex Allergy/Sensitivity: YES NO

SWALLOWING & FEEDING DISORDERS

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.

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 Health Services	_____
School Received/Sent to Health Services & School Staff	_____

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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
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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
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****Parent/Guardian signature required only for INITIAL (not updated) 2017-2018 PCP form.**

Emergency Contact	Telephone #	Relationship
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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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