Pasco County Schools

Gastrostomy/Jejunostomy Feeding Medical Management Plan

Student's Name: _____	Student ID: _____	DOB: _____	School Year: _____
School: _____	Diagnosis: _____		
Medication name, dosage, and frequency : _____		Medication to be administered via GT: ☐ No ☐ Yes	
Medication name, dosage, and frequency : _____		Medication to be administered via GT: ☐ No ☐ Yes	
Medication name, dosage, and frequency : _____		Medication to be administered via GT: ☐ No ☐ Yes	
Note: Parent must also complete authorization for medication administration			

Gastrostomy Tube Feeding Orders for School

Time(s) of Feeding/Duration: _____		Formula Type: _____
Bolus Amount:_____**ml**		Infusion (pump) Rate/Amt.: _____**ml/hr**
Amount of water for flush:		Other fluid for flush:
Feeding performed:	☐ By student ☐ By student under supervision of school nurse-trained staff ☐ By school nurse-trained staff	
If residual check is necessary, specify parameters to hold feeding:		
Is oral intake medically advised: ☐ No ☐ Yes if yes, indicate type and amount of intake allowable:		
Note: Continuous feedings will need to be disconnected during transition times including transportation		
If gastrostomy button/tube is displaced, trained staff may attempt reinsertion ☐ No ☐ Yes *Otherwise, trained staff will cover site with sterile dressing, secure with tape and notify parent.*		
Additional Comments:		

I hereby authorize the above-named physician and Pasco County School's staff to reciprocally release verbal, written, faxed, or electronic student health information regarding the above-named child for the purpose of giving necessary medication or treatment while at school. I understand Pasco County Schools protect and secure the privacy of student health information as required by federal and state law and in all forms of records, including, but not limited to, those that are oral, written, faxed, or electronic. I hereby authorize and direct that my child's medication or treatment be administered in the manner set forth in this medical management plan. I understand that all supplies are to be furnished/restocked by parents(s)/guardian.
I acknowledge that I am the parent/guardian of the student listed above and I have the rights and authority set forth in the Parent's Bill of Rights and related laws, and I further acknowledge that I have had the opportunity to review the district's resources identifying my rights (including the notices located at https://www.pasco.k12.fl.us/ssps/page/parent_notices, and pursuant the Parent's Bill of Rights, Chap.1014, Fl. Stat.), and my acknowledgement and my consent is indicated by my signature below. I understand that the form must be completed upon entry into school and at the beginning of each school year.

Physician's/Mid-Level Practitioner's Signature: _____ **Date:** _____

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

School Health Registered Nurse Signature: _____ **Date:** _____

Place Office Stamp Here