White River School District No. 416
240 North A Street * PO Box 2050 * BUCKLEY WA 98321 * 360-829-0600

PCMS – Licensed Health Professional's G-Tube Procedure Request at School

STUDENT NAME: _____ **DOB:** _____ **GRADE:** _____

SCHOOL (please check school of attendance):

☐	White River High School	Fax;	360-829-3351	☐	Glacier Middle School	Fax;	360-829-3391
☐	Elk Ridge Elementary	Fax;	360-829-3392	☐	Foothills Elementary	Fax;	360-829-3381
☐	Mountain Meadow Elementary	Fax;	360-829-3388	☐	Wilkeson Elementary	Fax;	360-829-3386

To Be Completed by a Licensed Health Professional with Prescriptive Authority

Type of Gastrostomy Tube: _____ Size: _____ Inflate _____ Date of Replacement: _____
Reason for Treatment: _____ G-Tube used for ☐ Feeding ☐ Medication ☐ Both
Type of formula/nutrient _____
_____ Time(s) of feeding(s): _____ and ☐ PRN
Can student eat/drink anything by mouth? ☐ Yes ☐ No If Yes, what? _____
Is student on a pump? ☐ Yes ☐ No If YES, what type? _____ Run at: _____ ☐ ml/hr
If student feeding requires pump, school staff may disconnect feeding for therapies & diapering/toileting? ☐ Yes ☐ No
Aspirate residual before feeding? ☐ Yes ☐ No If yes, amount: _____ ml
Vent before feedings? ☐ Yes ☐ No If YES, for how long? _____ Minute(s)
Flush with water after each feeding? ☐ Yes ☐ No If yes, amount: _____ ml
How is feeding usually tolerated? ☐ Good ☐ Poor Position needed for feeding: _____
Position needed after feeding: _____

If G-Tube is displaced at school: Check all applicable

- ☐ Parent and/or legal guardian has been trained to replace g-tube
- ☐ Child must see their doctor or surgeon for reinsertion of the g-tube
- ☐ If available, licensed health professional may replace g-tube

Hold feedings if: _____
Other instructions: _____
Duration of order(s): ☐ School Year ☐ (mm/dd/yr) _____ to _____

Health Care Provider's Signature	Telephone	FAX
Health Care Provider's Printed Name or Stamp	Date	

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY

To Be Completed by the Parent or Legal Guardian

G-Tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes.
I request that the school nurse or designated staff member be permitted to administer to my child, _____
the treatment prescribed by (name of health care provider) _____
for the school year ending June _____ (year). I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded. I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations
- I understand that a procedure will not begin until adequate training of qualified staff is completed
- I understand that I must provide all necessary supplies and equipment to perform this service

Parent/Guardian Signature	Home Phone	Work Phone
Date	Cell Phone	Other