

**Antelope Valley Union High School District
Gastrostomy Orders**

***** PHYSICIAN SECTION *****			
The Authorized Health Care Provider (signing below) must be licensed within the State of California to prescribe medication. (California Education Code 49423 and 49423.6)			
Student Name		DOB	Date Authorized
Parent / Guardian Name		Work / Cell Phone	
Parent / Guardian Name		Work / Cell Phone	
Type of Gastrostomy tube / device ___ GTT/ GJT ___ JT ___ Foley ___ Mic		Size ___ Fr.	Balloon ___ ml
		Measures ___ cm long (skin to tube tip)	
Times to be fed ___ a.m. ___ a.m. / p.m. ___ p.m.		Method ___ gravity ___ pump	
Name of Solution / Special diet		Amount of feeding (in ml)	
Do not feed if residual is greater than 50 % or ___ ml	Flush tube with ___ ml after meal	Vent tube ___ w/ feeds ___ prn	
If this procedure is required during school hours, these orders will be in effect until July 31 st of the summer following the school year for which they are prescribed.			
Name of Authorized Health Care Provider		Signature	
Address		Phone	
***** PARENT SECTION *****			
Initials required # 1,2 and 3 a or b			
1. I give my permission as the parent or legal guardian of the above named student to initiate this request for gastrostomy tube feedings for my child. I acknowledge that my child may be assisted with his / her feedings by a school employee trained by the District Nurse. Gastrostomy tubes that do not have matching information on the written statement and the package, or are not in their original package, will not be accepted or used. Gastrostomy tubes will be counted upon receipt in the health office. All equipment / supplies are the responsibility of the parent. ___ initials			
2. In order for gastrostomy tube feedings to be available to my child at school, I give my permission for the credentialed school nurse to communicate directly with the student's physician, as may be necessary, regarding the physician's written statement or any other questions that may arise with regard to the gastrostomy tube feeding. I may terminate my consent for administration of this medication at school at any time. ___ initials			
3a. My child has been trained to carry and self-feed and is both responsible and capable of performing this procedure, without assistance or supervision, at school. He / She is also capable and responsible to transport the gastrostomy tube to and from school. I release the district and school personnel from civil liability if my child suffers from an adverse reaction as a result of self-administering this procedure. ___ initials			
or 3b. I request that my child be assisted and supervised during administration of the gastrostomy tube procedure at school and not be permitted to perform this procedure without proper supervision from school personnel. ___ initials			
Signature of Parent / Legal Guardian			Date

Revised 2008