Cell

## ALABAMA STATE DEPARTMENT OF EDUCATION

## SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION FOR GASTROSTOMY TUBE CARE

		School Year:						
Student's Name		STUDENT INFORMATION						
School	Grade			Teacher			School Year	
Any known drug allergie	s/reactions? □ Y	es 🗆 No 🛚	If yes, please	list:				
	Г)		SCRIBER A					
START DATE:STO						P DATE:		
Type Formula	Reason for T	Reason for Taking		ute: eral	Amount per feeding:		Frequency/Time(s)	
RESIDUAL and FLUSH:	:				<u> </u>			
Check residual before feeding?       Flu         Yes □ No □       Yes         Notify prescriber if residual is greater       Flu		Yes □ _ Flush <b>a</b>	<b>before</b> formula?  □ ml. No □  n <b>after</b> formula?  □ ml. No □		Flush <b>before</b> medication administered?  Yes  ml. No  Flush <b>after</b> medication is taken?  Yes  ml. No  ml. No  ml.			
STORAGE: Formula requires refrigeration after opening? Yes □ No □ Syringe/tubing stored in refrigeration? Yes □ No □								
the Alabama Board the parent. The nurs  • If the gastrostomy b	ther: Lumen size  ered a mature step outton or tube become of Nursing, will reise will NOT inflate outton or tube become will be responsible thing or any change on Dressing Change on Dressing Change	oma (At lease dislodgensert the gethe tube/butes dislodgen opick up to in status oot):	French  east 6-8 weeks peged after this date astrostomy tubutton or Foley led before this the student. The ccurs 911 will	Length:  bost op)? Yes [  tte*, the schoo e/button or appoalloon and widate*, the schoo te nurse will N be called imme	cm.  No   *Date stomal nurse, who has receive propriate sized Foley call NOT provide an enterpol nurse will immediate OT attempt to reinsert	Balloca consider the terral feed ely call	on size: ml.	
Printed Name of Licensed	d Healthcare Pro	vider						
Signature of Prescriber		Da	ite	Phone		Fax		
I authorize the School Nurse, come up about the procedure. authorize the School Nurse to Procedure equipment and/or sunopened, sealed container ar	I understand that talk with the licens supplies must be reg	e (RN) or li additional ed healthc ristered wit	parent/prescrib are provider sh th the school no	al nurse (LPN) per signed state ould a questio urse, principal,	to talk with the prescri ements will be necessary n come up about the pro	y if the pocedure	procedure is changed. I also	
Signature of Parent			Date		Phone -		Cell	
(To be co I authorize and recommend so prescribed procedure by his/h of education against any clain	elf-care by my child ner attending physic	udent is a for the aborian. I sha	ove procedure. Il indemnify an	complete self- I also affirm i d hold harmle.	-care by licensed heal that he/she has been ins ss the school, the agent	structed	in the proper self-care of the	

Date

Phone

**Signature of Parent**