**Plano Independent School District**

**School Health**

**Enteral Feeding Orders**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Formula to be given via gastrostomy tube/button: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Amount of formula at each feeding: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Scheduled feeding at school/frequency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(give range of time when possible)

1. Feeding:

Gravity drip over period of \_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes.

Infuse feeding via feeding pump at rate of \_\_\_\_\_\_\_\_\_\_\_\_ ml/hr.

After each feeding, flush tube with \_\_\_\_\_\_\_\_\_\_\_\_\_ cc’s of tap/bottled water.

1. Check residuals prior to each feeding by lowering extension tube attached to syringe.  Replace residual.

If greater than \_\_\_\_\_\_\_\_\_\_\_cc’s, hold feeding for 30 minutes or \_\_\_\_\_\_\_\_ minutes, then recheck.

1. Vent gastrostomy tube/button as indicated for distention/discomfort.
2. Other instructions/precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:**

Adjustment in the treatment or discontinuation of the treatment requires a written, signed physician’s order. Order must be renewed each school year.

All equipment and supplies needed for enteral feedings will be provided by the parent.

Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Consent for Unlicensed Assistive Personnel to Enteral Feeding**

I **do / do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to enteral feeding, to my child while in attendance at Plano ISD or Plano ISD related events (such as field trips and athletic events), when a trained medical professional may not be available.I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent initials** \_\_\_\_\_\_\_\_

**Parent/Guardian Consent to Share Information and Picture**

I **do /**  **do not** (check one) authorize Plano ISD to display a picture of my child (if applicable) and identify that this is a person with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year.

**Parent initials \_\_\_\_\_\_\_**

**Parent/Guardian Authorization for School Staff to Communicate Health Information**

*I authorize the District’s designees, including District medical professionals and UAPs, to share/obtain my student’s health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student’s IHP, 504 plan, IEP, or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any Health Care Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child’s Individually Identifiable Health Information. School-related health services described in this agreement shall not be provided to a student without the required consent of the parent/guardian, as outlined herein.*

**Parent initials** \_\_\_\_\_\_\_

**Parent/Guardian Release of Claims Against District and Agreement to Indemnify**

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the Administration of Medication to the student, Treatment/Procedure and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff’s Administration of Medication and/or Treatment/Procedure described in this document to the student and/or the disclosure of Individually Identifiable Health Information,, including but not limited to claims that School Staff negligently failed to recognize symptoms requiring the use of my child’s Medication/Treatment/Procedure, misconstrued symptoms which it believed necessitated the use of my child’s Medication/Treatment/Procedure, negligently administered or failed to administer Medication(s), Treatment/Procedure and/or “over-disclosed” my child’s Individually Identifiable Health Information.

The School Health Administrative Guidelines developed by the Plano Independent School District are subject to the Americans with Disabilities Act (“ADA”), 42 U.S.C. §12101, et seq.; Section 504 of the Rehabilitation Act of 1973 (“Section 504”), 29 U.S.C. § 701, et seq.; and the Individuals with Disabilities Education Act (“IDEA”), 20 U.S.C. § 1400 et seq.

Parent’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_