I understand that treatments may be administered in MCPS by non-health professionals. These individuals may be employees of MCPS who are designated to administer the treatment(s), or the DHHS School Health Room Technician. These persons will be trained by the School Community Health Nurse (SCHN) to give the specific treatment.

**Reason for Treatment/Diagnosis:**
________________________________________________________________________

**Type and size of Gastrostomy Tube:**
________________________________________________________________________

**Formula name:**
________________________________________________________________________

**Feeding Schedule/times during the school day (include volume per feed and any free water bolus):**
________________________________________________________________________
________________________________________________________________________

**Feed Method:**

- [ ] Slow drip rate:__________
- [ ] Feeding pump-rate:__________
- [ ] Gravity Drip–over how long__________

**Check for residual before bolus feedings?**

- [ ] Yes  
- [ ] No  

If YES, return residual if less than__________ ml

**Flush with water after each bolus feeding?**

- [ ] Yes  
- [ ] No  

Amount:__________ ml

**Venting:**

- [ ] Yes  
- [ ] No  
- [ ] Active  
- [ ] Passive  
- [ ] Duration__________

**If G-Tube becomes dislodged at school:**

- [ ] Parent and/or legal guardian can replace G-Tube
- [ ] School nurse to replace G-Tube and call parent
- [ ] Child must see their doctor or surgeon for reinsertion of the g-tube
- [ ] Call 911  
- [ ] Other__________________________________________

**Student is allowed to have food/drink by mouth?**

- [ ] Yes  
- [ ] No  

If YES, what restrictions if any exist?
________________________________________________________________________
________________________________________________________________________

*Medications to be given at school require completion of the MCPS 525-13, Authorization to Administer Prescribed Medication.*

**Authorized Prescriber’s Name (print/type)_________________________**

**Phone____-____-______**

**Authorized Prescriber Signature_________________________**

**Date____/____/______**

**Medication order effective**

- [ ] Current school year, OR  
- [ ] Effective dates____/____/______ to____/____/______

**Signature, School Community Health Nurse (SCHN)/Principal_________________________**

**Date____/____/______**