*Return completed form to:*
*Jefferson County Public Schools,*
*Health Services Department, LAM Building*
*4309 Bishop Lane, Louisville, KY 40218*
*Telephone # (502) 485-3387*
*Fax # (502) 485-3387*

# JEFFERSON COUNTY PUBLIC SCHOOLS
# SCHOOL HEALTH PLAN
# G-Tube

**School Year:**

***Please print neatly. Por favor, escriba legible***

## PART A Parent / Guardian: Complete Items 1 - 11 *(Padre/madre/tutor: complete la información en los espacios 1 al 11)*

**1) Student ID#** *(Numero de estudiante)* | **2) Student's Last Name** *(Apellido)* | **3) Student's First Name** *(Nombre del estudiante)* | **4) Date of Birth** *(Fecha de nacimiento)*

**5) School** *(Escuela)* | **6) Grade** *(Grado)*

**Parent/Guardian Name & Contact Information** ***(Nombre & Información del contacto)***

**7)** Name *(Nombre)* | **8)** Phone Number *(Teléfono)* ( ) - | **9)** Mailing Address, City, State, Zip *(Dirección posta, ciudad, estado, código postal)*

**10)** Emergency Contact (Contacto de emergencia y Teléfono) ( ) -

**11) Note to parent/guardian:** Signing this form shall release the Jefferson County Board of Education and its employees from liability of any nature that might result from this plan of action. This form shall not relieve the liability of the school or its employees for their own negligence. Also, I hereby give permission for the healthcare provider completing and signing this form to exchange information with JCPS staff regarding this health condition. I acknowledge and agree when I authorize my child to attend a school sponsored field trip these medications and/or health services may also be provided by a licensed volunteer.
**Parents please note: In order for medications to be administered, parent must complete an "Authorization for Medication" form for each medication needed at school.**

**PARENT/GUARDIAN Signature** X | **TELEPHONE NUMBER** ( ) - | **DATE**

## PART B COMPLETED BY THE HEALTHCARE PROVIDER ONLY: Complete Items 12 – 24
(12 al 24 - Esta sección para ser completada por el médico solamente.)

**12) LATEX ALLERGY/SENSITIVITY:** ☐ **YES** ☐ **NO**

**13) Student Diagnosis:**

**14) Type of Feeding Tube**
☐ **NG Tube** ☐ **NJ Tube** ☐ **G Tube** ☐ **J Tube** ☐ **GJ Tube** ☐ **Other:**_____

**15) Is child allowed to have any food/drink by mouth?** ☐ **YES** ☐ **NO**

**16)** Name of Formula: _____ Volume to be given: _____ml
**Feeding formula must be sent to school in a labeled container with ingredients listed

**17) Pump to be used:** ☐ **YES** ☐ **NO**

**18) Gravity:** ☐ **YES** ☐ **NO**

**19)** Feeding Time(s): _____ _____ _____ _____

**20)** Additional volume of water: _____ ml Water times: _____ _____

**21) May additional water be administered for outdoor field trips during warm water:**
☐ **YES** Amount: _____ ml ☐ **NO**

**22) If Feeding Tube becomes dislodged can a Trained Nurse replace it?** ☐ **YES** ☐ **NO**

**23)** Additional Health Care Provider's Comments:

_____

_____

_____

**24) Healthcare Provider Information** Form **must** be signed by a Healthcare Provider **and** parent/guardian

Healthcare Provider Signature X | Date

Healthcare Provider Printed Name

Medical Office Stamp (required for processing)