

MONTGOMERY COUNTY PUBLIC SCHOOLS

በ ጋስትሮስቶሚ ቱቦ የመመገብ ፈቃድ "Gastrostomy Tube Feeding"

የትምህርት ቤቶች የጤና መኮንን ቢሮ Office of the School System Medical Officer
MONTGOMERY COUNTY PUBLIC SCHOOLS ሞንትጎመሪ ካውንቲ ፕብሊክ ስኩልስ
Rockville, Maryland 20850

ክፍል I በወላጅ/በአሳዳጊ የሚሞላ

የሞንትጎመሪ ካውንቲ ፕብሊክ ስኩልስ (MCPS) እና የሞንትጎመሪ ካውንቲ የጤና እና ሰብአዊ አገልግሎት መምሪያ (DHHS) ሰራተኞች ከዚህ በታች (ክፍል II) እንደተገለጸው ፈቃድ ባለው ሀኪም የታዘዘውን ምግብ እንዲሰጡ እና በህክምና የታዘዘውን እንዲያከናውኑ መጠየቁን እና የፈቃድኩላቸው መሆኑን አረጋግጧል። MCPS እና DHHS እና ማናቸውም አፈሰርቻቸውን፣ ሰራተኞቻቸውን ወይም ተወካዮቻቸውን ከክስ ነጻ ለማድረግ፣ የይገባኛል ጥያቄ ላላገኘ፣ ወይም ለዚህ(ች) ተማሪ በክፍል II እንደተገለጸው የተፈቀደውን የሐኪም ትዕዛዝ የ MCPS እና የ DhHS ሰራተኞች እንዲያከናውኑ ተስማምቻለሁ። ምግቡ ሊሰጥ የሚችለው በአፈሰር፣ በሥራ ባልደረባ፣ ወይም በሰራተኛ፣ ወይም ፈቃድ ካለው የጤና ባለሙያ ስልጠና በወሰደ(ች) የጤና ባለሙያ ያልሆነ ሰው አማካይነት መሆኑን ተረድቻለሁ። HCP ትዕዛዝ ላይ ለውጦች ከተደረጉ ወይም ከተሠረዙ ለት/ቤቱ የጤና ሰራተኞች ወዲያውኑ አሳውቃለሁ። ይህንን አገልግሎት ለማከናወን አስፈላጊ ቁሳቁሶችን እና መሳሪያዎችን ሁሉ ማቅረብ እንዳለብኝ ተረድቻለሁ።

የተማሪው/ዋ ስም: የአያት ስም _____ መጠሪያ ስም _____ የአባት ስም የመጀመሪያ ፊደል _____

MCPS መታወቂያ ቁጥር ID# _____ የተወለደ(ች)በት ቀን ____/____/____ የት/ቤት ስም _____

ፊርማ ወላጅ/አሳዳጊ _____ ስልክ _____ - _____ - _____ ቀን ____/____/____

ክፍል II:- መድኃኒት የማዘዝ ፈቃድ ባለው/ባላት የጤና ባለሙያ (ሃኪም) የሚሞላ

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, return residual if less than _____ ml
Flush with water after each bolus feeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount: _____ ml
Venting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Duration _____
If G-Tube becomes dislodged at school: (check all that apply)	<input type="checkbox"/> Parent and/or legal guardian can replace G-Tube <input type="checkbox"/> School nurse to replace G-Tube and call parent <input type="checkbox"/> Child must see their doctor or surgeon for reinsertion of the g-tube <input type="checkbox"/> Call 911 <input type="checkbox"/> Other _____	
Student is allowed to have food/drink by mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 ____/____/____

ክፍል III መሞላት ያለበት በትምህርት ቤቱ የማህበረሰብ ጤና ነርስ ወይም በርእሰ መምህር ነው።

Signature, School Community Health Nurse (SCHN)/Principal _____ Date ____/____/____