



FREEDOM AREA SCHOOL DISTRICT

Freedom Area School District
Health Services
Amie Kazik RN, BSN, District Nurse
Phone: 920-788-7944
DO Fax: 920-788-7949
ES Fax: 920-788-7956

Student Name:	DOB:	Date:
School:	Grade:	Bus Student: Yes No
Co-Curriculars:		
Health Condition: G-tube Feeding		
Name of Formula:		
Type of Pump:	Gravity: ___ Yes ___ No	
Volume to be given: _____ ml (milliliters) Over _____ minutes	Feeding Times:	
Position during Feeding:		
Position after Feeding:		
Note to Health Care Provider/Parent/Guardian: 1. The parent/guardian will be notified if a tube becomes clogged or dislodged. 2. Feeding formula must be sent to school in the original unopened container		
Medication Consent: I hereby give permission to designated trained school personnel to give medications to my student during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold Freedom Area School District employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.		
Students health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff, and other pertinent FASD staff.		
By signing you agree you have reviewed this health plan for your student and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.		
Parent's signature:	Date:	
Physician's signature:	Date:	
Physician Phone:	Physician Fax:	