Enteral Feeding Treatment Authorization Form

Student's Name	Sex	Date of Birth	Student #
School		Grade	

This form provides professional and parental authorization for medical treatment to be provided during school hours. Both the prescribing physician or health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Note: Physician's orders are required for all medical procedures administered at school. Please have your child's physician complete this portion of the form and return it to the school or have them fax it to the school nurse.

Physician's Order

The following section is to be completed by the prescribing physician or health care provider:
The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.

Diagnosis for which tube feeding will be required in school:			
Type of gastrostomy appliance placed: Peg _____ Button _____ G-Tube _____ Other, describe _____			
Type of tube feeding formula:		Amount:	
Type of tube feeding flush:		Amount:	
Time and frequency of feedings:			
Is it necessary to measure residual stomach contents? Yes_____ No _____ If yes, will the residual content alter feeding volume? Yes _____ No _____ If yes, please indicate the residual amount that would prohibit feeding at the prescribed time ____ cc total volume.			
Tube feeding method: Bolus by gravity _____ Bag _____ Syringe _____ Mechanical Pump _____ If Mechanical pump – Type of pump _____ Rate of flow _____ If pump malfunctions may do bolus feeding Yes_____ No_____			
Is student allowed oral feedings? Yes _____ No _____ If yes, Type: _____ Frequency: _____			

Physician's Name (Print) _____ Phone #_____ Fax # _____

Physician's Signature _____ Date_____

Parent/Legal Guardian Permission

The following section is to be completed by the parent/legal guardian:
I hereby grant permission to the principal or his/her designee of _____ school to assist in the administration of the above prescribed treatment to my child while in school and away from school while participating in official school activities. **I understand that it is my responsibility to notify the school if and when these orders change.** I also understand these orders are valid for 1 school year. I am aware if my child's G-Tube is dislodged or removed, it will not be replaced by school personnel. If it becomes dislodged, it will be covered and I will be contacted immediately by school personnel to seek medical attention and direction for my child.

Special Instructions:					
Precautions to monitor:					
My child has:	No allergies_____ The following allergies:				
Parent/Guardian Name:				Relationship:	
Home phone:		Business phone:		Emergency phone number:	

1. I give permission for my child's doctor to be contacted for information regarding the administration of the treatment listed on this form.
2. I agree to provide all treatment supplies.
3. I will pick up all supplies on or before the last day of school or allow the school to discard them, if not picked up.

Parent/Guardian Signature _____ Date _____

Campus Nurse Signature _____ Date _____ Campus Principal_____ Date _____

District Nurse Signature_____ Date_____