Licensed Health Provider's Feeding Tube Procedure Request at School

Student Name	DOB	School	Fax	School Year

To Be Completed by a Licensed Health Provider with Prescriptive Authority

Type of Feeding Tube	☐ G-Tube ☐ J-Tube ☐ GJ-Tube | Brand/ Profile_____ Inflate _____
Method of Delivery- Feeding	☐ G-Tube ☐ J-Tube
Method of Delivery- Medications	☐ G-Tube ☐ J-Tube ☐ Other_____
Formula Name/ Recipe	_____ Prepared by family ☐ Yes ☐ No
Feeding Infusion Rate	_____ ml/hr Parent can adjust rate ☐ Yes ☐ No No slower than _____ml/hr ; No faster than _____ml/hr
Frequency or Duration	☐ Continuous Feed _____ hrs/day ☐ Bolus/Total volume _____ml Times of feeding _____ Parent can adjust timing ☐ Yes ☐ No Parent determined time(s) _____
Feeding Method	☐ Bolus ☐ Gravity ☐ Pump (Type of Pump_____)
Position During / After Feeding	
Venting the G-Tube	☐ Yes ☐ No | ☐ Before feeds ☐ After feeds ☐ Continuous
Water Bolus Via G-tube	☐ Yes ☐ No Amount_____ ml Frequency _____
Water Flush	☐ Yes ☐ No Amount_____ ml Frequency _____ ☐ G-Tube ☐ J-Tube
Pause or Hold Feeds	☐ Toileting ☐ Position Changes ☐ Gagging/ Retching ☐ Bus Ride
Oral Feeding Restrictions/ instructions including any volume restrictions	
Additional Considerations in a 72-hour emergency	

If Tube is displaced at school, cover and (*Check all applicable boxes).* ☐ Parent and/or legal guardian has been trained to replace tube
☐ Child must see their doctor or surgeon for reinsertion of the tube.

Other instructions: _____

_____

Duration of order(s): ☐ School Year ☐ (mm/dd/yr) _____ to _____.

Health Care Provider's Signature _____ Phone _____ Fax _____

Health Care Provider's Printed Name or Stamp _____ Date _____

THIS AUTHORIZATION IS GOOD FOR THE CURRENT SCHOOL YEAR ONLY.

To Be Completed by the Parent or Legal Guardian

Feeding Tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes.

I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child, *(name of child)* _____ , the treatment prescribed by *(name of health care provider)* _____ for the _____ school year. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed.
- I understand that I must provide all necessary supplies and equipment to perform this service.

Parent/Guardian Signature: _____ Date: _____

Phone Contacts: *Home* _____ *Cell* _____ *Work* _____ *Other* _____