OLENTANGY SCHOOLS℠
Flourish Here.

HEALTH CARE PROVIDER AUTHORIZATION AND RECOMMENDATIONS FOR MIC-KEY GASTROSTOMY (G) OR GASTROJEJUNOSTOMY (GJ) TUBE FEEDING

Student's name: _____ Birthdate: _____

School: _____ Grade: _____

Student's diagnosis: _____

Type of feeding tube: □ G □ GJ □ □ Mic-Key

This is to certify that the above named student is under my care and needs to receive gastrostomy or gastrojejunostomy tube feedings during schools hours as ordered below. I understand that some of these feedings may be administered by medically unlicensed school staff that will be trained and monitored by a school nurse. (*Note: If student is also receiving assisted oral feedings, please complete both provider forms for the school - #5311A F3 and #5311A F4.)

GASTROSTOMY OR GASTROJEJUNOSTOMY TUBE FEEDING(s)

Times(s) to Administer	Type and Amount of formula, juice, milk	Amount of water	Rate to Feed (as bolus over "X" minutes or as continuous feed over "X")
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please note position of student: During feeding _____

After feeding _____

Precautions, possible complications, and recommended interventions. (Note that school staff do not reinsert G or GJ tubes.)

_____

_____

_____

Other comments:

_____

_____

_____

Beginning date for order: _____ Ending date for order: _____

Provider's signature: _____ Office #: _____

Provider's printed name:_____ Fax #: _____

Office address: _____