Virginia Beach City Public Schools: Health Services
PHYSICIAN'S AUTHORIZATION FOR ENTERAL FEEDING
School Year: _____

STUDENT'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM

I. PHYSICIAN ORDER

DIAGNOSIS: _____

Gastrostomy Tube: Yes ☐ No ☐ Fundoplication: Yes ☐ No ☐

Food Allergies: Yes ☐ No ☐ Type _____

ORAL FEEDINGS:

☐ NO oral feedings or liquids
☐ Thin liquids (oral)
☐ Regular diet (oral)
☐ Pureed diet (oral)
☐ Thickened liquids (oral); Specify: _____
☐ Other: _____

Video Swallow Study: Yes ☐ No ☐ Date_____ Result _____

G-TUBE FEEDINGS:

☐ NO tube / button feedings at school
☐ Gravity feeding over period of_____minutes
☐ Pump feeding at a rate of _____cc/hour
☐ Flush with_____cc water after feedings and medications

FORMULA:_____ Amount: _____

FREQUENCY:

☐ Once per day at school ☐ Twice per day at school
☐ Every_____hour(s) ☐ Other: _____

I authorize the School Nurse to replace the Gastrostomy Button/tube in case of malfunction.
(**Parent/Guardian will provide extra button**) Yes ☐ No ☐

PRINT PHYSICIAN'S NAME _____ PHYSICIAN'S SIGNATURE

PHYSICIAN'S ADDRESS _____ PHYSICIAN'S PHONE NUMBER _____ DATE

II. AUTHORIZATION RELEASE/OBTAIN INFORMATION & CONSENT FOR SERVICES

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

I request and authorize the school nurse and trained school personnel to administer enteral feedings (tube feedings) as prescribed by my child's physician. I will provide the school with the necessary supplies/equipment to perform this service for my child. I will also provide written notification from the physician if the treatment changes or is discontinued. This authorization will be in effect for the above stated school year.

PARENT'S/GUARDIAN'S NAME _____ PARENT'S/GUARDIAN'S SIGNATURE _____ DATE

III. SCHOOL NURSE ACKNOWLEDGEMENT

SCHOOL NURSE NAME _____ SCHOOL NURSE SIGNATURE _____ DATE