Carroll County Public School

Attach Photo	**Enteral Feeding Tube Authorization Form** This order is valid only for the current school year _____ (Including summer school) **OR** Start Date: _____/_____/_____ to Stop Date: _____/_____/_____ This treatment authorization form must be completed fully in order for staff to administer the required treatment. A new form must be completed at the beginning of each school year and with any changes in health care provider orders

Name of Student:	*Date of Birth:*	*Grade:*

HEALTH CARE PROVIDER AUTHORIZATION

Reason for Treatment:	Allergies:		
Method of Infusion:	Time of Administration:	Feeding or Mixture Instructions:	Route:
☐ Brand Of Pump_____ ☐ Pump Rate: _____ Volume: _____ ☐ Gravity Volume: _____ over _____ minutes ☐ Bolus Volume: _____ over _____ minutes			☐ Gastrostomy Tube ☐ Jejunostomy Tube ☐ Nasogastric Tube

Flush feeding tube with _____ ml of water
Venting Orders: _____
In case of pump failure: _____

*Other special considerations*_____

Treatment instructions: (only a RN/LPN can reinsert a feeding device). Initial post-surgery tube changes will not be completed by the school nurse.

If gastrostomy device is dislodged, the nurse will:
Insert new gastrostomy device size _____ Fr. & _____ cm or cover with dry sterile gauze and notify parent_____
If parent does not arrive within _____ minutes call 911
If the nurse is not available or if the tube cannot be reinserted, maintain stoma patency by: _____
Extension tubing change frequency: _____
Bag change frequency:_____
Bag/extension tubing will be changed more frequently at the nurse's discretion

Is student competent to self-administer treatment? Yes No

Health Care Provider's Name/Title: (please print)

Telephone: Fax:

Address:

Health Care Provider's Signature: ***Date:***

Parent/Guardian Signature: ***Date:***

SCHOOL NURSE REVIEW / AUTHORIZATION

Is the student competent to self-administer treatment? Yes No

School Nurse Signature: ***Date:***