CALALLEN INDEPENDENT SCHOOL DISTRICT
Health Services Department
ENTERAL FEEDING REQUIRED AT SCHOOL
Physician Orders/Parent Permission
SCHOOL YEAR 20____-20____

Student Name: _____ Grade: _____ ID#: _____ DOB: _____

☐Gastrostomy ☐Jejunostomy Device: ☐Tube ☐Button Diagnosis: _____

PROCEDURE:

1. Recommended method for verifying feeding tube placement:
_____

2. Formula: _____ Amount: _____ Time(s): _____
(Please give range of time, when possible, to accommodate school schedule)

3. Method: ☐ Gravity drip over period of _____ minutes. ☐ Feeding pump at rate of _____ ml/hr.
After each feeding, flush the tube with _____ cc's of tap water.

4. Position child with head and upper body elevated at least 45 degrees. Keep child upright after feeding for _____ minutes.

5. ☐Do check for residual prior to feeding ☐Do not check for residual prior to feeding
If residual is greater than _____cc's, hold feeding for ____ minutes, then recheck.
If residual remains greater than _____ cc's after _____ minutes, hold/give (circle one) feeding.

6. If the tube becomes clogged:
_____
_____

7. Clean ostomy site: ☐every feeding ☐daily ☐only as needed ☐other: _____

Note:
Adjustment in the treatment or discontinuation of the treatment requires a written, signed physician's order.
Order must be renewed each school year.
All equipment and supplies needed for enteral feedings will be provided by the parent.

ADDITIONAL INSTRUCTIONS/PRECAUTIONS:

_____
_____

_____ _____
Printed Name of Physician Physician Signature

_____ _____ _____
Date Office Phone Office Fax

Parent/Guardian Consent for Unlicensed Assistive Personnel to Enteral Feeding

I ☐**do /** ☐**do not** (check one) authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a campus nurse to enteral feeding, to my child while in attendance at Calallen ISD or Calallen ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent initials** _____

Parent/Guardian Consent to Share Information and Picture

I ☐**do /** ☐ **do not (**check one) authorize Calallen ISD to display a picture of my child (if applicable) and identify that this is a person with health conditions. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year.

Parent initials _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and UAPs, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other CISD form requesting for school health care services.

Parent initials _____

Parent's Name_____ Phone_____

Parent's Signature_____ Date_____