

**PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for
Management of a Feeding Tube in Educational Settings and Sponsored Events**

Student:	DOB:	Date:
District/Site:	Teacher/Rm:	Grade:

<p>1. Latex Allergy: <input type="checkbox"/> YES <input type="checkbox"/> No</p> <p>2. Type of feeding tube: <input type="checkbox"/> G-tube <input type="checkbox"/> G-J tube <input type="checkbox"/> J-tube <input type="checkbox"/> PEG-J tube</p> <p>3. Type of device: <input type="checkbox"/> MIC-KEY™ <input type="checkbox"/> Foley - adjust. Length _____ <input type="checkbox"/> Mini-ONE® <input type="checkbox"/> NG - adjust. Length _____ <input type="checkbox"/> Bard <input type="checkbox"/> Other: _____ Size: _____</p> <p>4. Tube Feeding: Time(s) of feeding: _____ Formula: _____ Amount/feeding: _____ Water- Amount before feeding: _____ Amount after feeding: _____ Other: _____ Feeding method: <input type="checkbox"/> Bolus – duration of feeding: _____ <input type="checkbox"/> Gravity - bag height: _____ <input type="checkbox"/> Pump - rate: _____ Student's position during feeding: _____</p> <p>5. Residual: <input type="checkbox"/> NOT necessary <input type="checkbox"/> Check before every feeding <input type="checkbox"/> Hold feeding if residual > _____ Additional instructions: _____</p> <p>6. Medication administered via g-tube at school: <input type="checkbox"/> No <input type="checkbox"/> Yes (medication authorization(s) attached)</p>	<p>7. Decompression: <input type="checkbox"/> NOT needed <input type="checkbox"/> Before feeding <input type="checkbox"/> After feeding <input type="checkbox"/> During feeding <input type="checkbox"/> PRN signs/symptoms: _____ Duration of decompression: _____</p> <p>8. If gastrostomy tube becomes dislodged: <input type="checkbox"/> Cover site and notify parent. <input type="checkbox"/> Use a catheter to maintain temporary ostomy patency by RN/LVN/UAP (unlicensed assistive personnel). <input type="checkbox"/> Insert gastrostomy tube by RN/LVN/UAP. <input type="checkbox"/> Insert skin-level button by RN/LVN/UAP. <input type="checkbox"/> Other: _____ Reinsertion must occur within:</p> <p>9. Fundoplication: <input type="checkbox"/> No <input type="checkbox"/> Yes, date: _____</p> <p>10. Oral feedings: Feeding evaluation: <input type="checkbox"/> No <input type="checkbox"/> Yes (copy attached) <input type="checkbox"/> NPO (nothing by mouth) <input type="checkbox"/> Tiny tastes of food/liquids <input type="checkbox"/> Thin liquids (e.g., formula, milk, juices, water, popsicle) <input type="checkbox"/> Thick liquids (e.g., nectar, milkshake, ice cream, yogurt, thickened juices) <input type="checkbox"/> Thickener: _____ Amount: _____ <input type="checkbox"/> Pureed foods (e.g., applesauce) <input type="checkbox"/> Other: _____</p> <p>11. Other pertinent information or recommendations:</p>
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Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

*Authorized Health-Care Provider Name _____ *NPI Number _____

Signature _____ Date _____

Phone _____ Address _____ City _____ Zip _____

Supervising Physician Name _____ NPI Number _____

Phone _____ Address _____ City _____ Zip _____

I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of a Feeding Tube in Educational Settings and Sponsored Events

Student: _____	DOB: _____	Date: _____
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Authorization for Trained Unlicensed Person	
Feeding may be performed by a trained unlicensed person. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medication administration via feeding tube may be performed by a trained unlicensed person. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Health-Care Provider Signature: _____	Date: _____
Parent Signature: _____	Date: _____

Parent Consent for Authorization and Management in the Educational Setting	
I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.	
I (we) will:	
1. provide the necessary supplies and equipment;	
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and	
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.	
I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.	
I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).	
Parent(s)/Guardian(s) Signature: _____	Date _____
_____	Date _____

Reviewed by credentialed school nurse (signature) _____ Date _____

Credentialed school nurse has informed principal about health-care services provided for this student.