Enteral Feeding Treatment Authorization Form

Student Name: _____ DOB: _____

Student ID: _____ Campus: _____

This form provides professional and parental authorization for medical treatment to be provided during school hours. Both the prescribing physician or health care provider and the parent/legal guardian is required to complete the respective sections of this document entirely before the services can be provided.

Physician's Statement	
The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment that is necessary to be provided during school hours for the child's health and/ or safety. I am also aware that the prescribed treatment (except re-insertion of the g-button) may be administered by trained, non-medical personnel. **If the G-button was to become dislodged requiring re-insertion:** ⬜ I confirm the student named in this document has an established tract, and that if needed, may be accessed by a parent/ guardian, trained RN, or trained emergency contact.	
Physician's Order **The following section is to be completed by the health care provider:**	
Type of Gastrostomy Appliance Placed: Peg _____ Button _____ G-Tube _____ Other, describe _____	
Date of Initial Insertion:	**Tube/ Device Size (Fr and cm):**
Type of Water to Fill Balloon: Tap Water _____ Other, describe_____	**Volume of Water in Balloon (mL):**
Type of Tube Feed:	**Amount:**
Type of Tube Feed Flush:	**Amount:**
Time & Frequency of Feedings:	
Is it necessary to measure residual stomach contents? Yes_____ No _____ If yes, will the residual content alter feeding volume? Yes _____ No _____ If yes, please indicate the residual amount that would prohibit feeding at the prescribed time: _____ mL total volume.	
Tube Feed Method: Bolus by Gravity _____ Bag _____ Syringe _____ Mechanical Pump _____	
If Mechanical pump- Type of Pump: _____ Flow Rate: _____	
If pump malfunctions May Do Bolus Feeding: Yes_____ No_____	
Is the student allowed oral feedings? Yes _____ No _____ If yes, Type: _____ **Frequency:** _____	

Physician's Name (Print): _____

Physician's Signature: _____ Date: _____

Phone: _____ Fax: _____

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Revised 06/2024

Parent/Legal Guardian Consent to Treatment: **The following section is to be completed by the parent/legal guardian:**
⬜ I consent to the campus nurse and trained campus staff at _____ school to assist in the administration of the above prescribed treatment to my child while in school and away from school while participating in official school activities.
⬜ I give consent for my child's doctor to be contacted for information regarding the administration of the treatment listed on this form.
⬜ I understand that it is my responsibility to notify and provide a new completed form to the school when these orders change.
⬜ I understand these orders are valid for 1 school year.
⬜ I agree to provide all treatment supplies. I will pick up all supplies on or before the last day of school, or allow the school to discard them, if not picked up.
If my child's g- button is dislodged OR removed: ⬜ I give consent for a trained campus RN or trained emergency contact to re-insert my child's g- button. Please complete & sign the *G- Button Reinsertion to Prevent Closure of Stoma Guidelines, Trained Emergency Contacts & Consent* form. ⬜ I **DO NOT** give consent for a trained campus RN or trained emergency contact to re-insert my child's G-button. If it becomes dislodged, please cover the sight, and contact me immediately, so I may seek medical attention and direction for my child.

Parent/ Guardian Name (Print): _____

Parent/Guardian Signature: _____ Date: _____

Phone (Cell): _____ Phone (Work): _____