School Year: _____

# CONSENT AND ORDER FOR GASTROSTOMY OR JEJUNOSTOMY FEEDING CARE-HEALTH SERVICES

## PARENT/GUARDIAN CONSENT FOR GASTROSTOMYOR JEJUNOSTOMY FEEDING CARE

I give my permission for the school nurse or a staff member trained by the school nurse to perform the following specialized nursing intervention or treatment prescribed by_____ (Physician or Licensed Care Provider) and to contact the Physician regarding any treatment orders, the implementation of the orders, and the outcomes from these treatments. I request that the school continue the intervention or treatment for the duration of the school year or until notified by me or the Physician to change or discontinue. Notice of change must be received in writing. Orders must be renewed annually.

_____ _____

Parent/Guardian Signature Date

## PHYSICIAN'S ORDER FOR GASTROSTOMY OR JEJUNOSTOMY FEEDING CARE

**Student Name**_____**Allergies**_____**Date of Birth**_____

**Condition/Diagnosis**: _____

**Specialized Intervention**: ☐ **G-Tube Feeding & Care** ☐ **G/J Tube Feeding & Care**

**Size of Tube**: Diameter:_____(f) Length:_____(cm) Amt. in Balloon: _(ml) of : ☐ Sterile ☐ Tap Water

**Formula:** _____Amt: _____Time/Freq: _____

**Feeding type:**

☐ **Bolus by Gravity**: ☐ Bag ☐ Syringe

☐ **Continuous Feeding Pump**: Rate: _____ml/hr. Duration of Feeding: _____

☐ **Flush:** Amt: _____

**Instructions for Nurse if G-Tube Dislodges:**

(If G/J tube dislodges, parent/guardian and health care provider will be contacted)

☐ Do Not Replace G-Tube (cover and contact physician & parent)

☐ Replace G-Tube

**Comments Regarding Residual/Emesis/Venting:** _____

_____

**Any other Precautions Or Recommended Interventions:** _____

_____

Physician name (please print) _____

Address_____Phone_____Fax #: _____

**Physician Signature:** _____**Date**: _____

*If completed by an APRN, please indicate your collaborating physcian:_____

***Please return by mail or fax to the address or fax # below:***

School Name: _____School Address_____

Phone: _____Fax: _____Requesting Nurse: _____