



Clayton County Public Schools

Authorization for Gastrostomy Tube Feeding

School _____ **School Year** _____

Student's Name _____ Student Number _____ Date of Birth _____

Teacher _____ Grade _____ Allergies _____

Student's Primary Physician _____ Phone _____

We (I) the undersigned, who are the parents/guardians of _____
request that the following specialized procedure is administered to our child.

Procedure: Gastrostomy Tube Feedings

We (I) understand that the designated school personnel under direct or indirect supervision will do the procedure after appropriate training. It is also understood that Clayton County Public School personnel are released from responsibility for any complications resulting from administration of this procedure. We (I) will notify the school immediately if the health of our child changes, we change physicians or there is a change or cancellation of this procedure. We (I) understand that whenever possible the specialized procedure should be provided by the family before or after school hours.

Parent/Guardian Signature _____ Date _____

Formula _____ **Frequency** _____

Amount _____ **Pump** _____ **Rate** _____ **Bolus** _____ **Amount of Water** _____

To be completed by Physician:

Health Condition for which this procedure is to be performed:

Precautions, possible untoward reactions, recommended intervention(s)/other comments:

Physician Printed Name _____

Address _____

Phone _____ Fax _____

Physician Signature _____ Date _____