



G-tube Feeding & Reinsertion of Gastrostomy Tube for Pupil: Physician Authorization

Name of Student: _____ Birth Date: _____

1. Name of formula to be given: _____
2. Amount of formula to be given: _____ Amount of water to be given: _____
3. How feeding is to be given: Bolus _____ Pump _____ (specify rate): _____
4. The student should receive feeds at the following times: _____
5. The feeding times and amount may be changed if requested by parent and approved by school nurse
Yes _____ No _____
6. May have foods/liquids orally? Yes _____ No _____. If yes, please specify: _____
7. I authorize the School Registered Nurse to reinsert the gastrostomy tube into pupil. Yes _____
No _____
 - a. The school health staff is allowed to feed this student after reinsertion. Yes _____ No _____
 - b. This student should be checked by a physician before feeding following reinsertion of gastrostomy tube. Yes _____ No _____
8. The medical justification for providing the procedure(s) during school hours is:

9. Please list any signs or symptoms that may indicate an emergency situation along with the emergency procedures: _____

10. List any concerns about transporting the student on the school bus: _____

11. I understand the procedures:
 - a. Should require a minimal amount of additional training.
 - b. Should not require the presence of a physician, medical judgment based on extensive medical training, or an undue amount of time to be provided or performed.
 - c. **Must** be provided or performed **during the school day** so that the student can attend school or benefit from his or her educational program
 - d. Must be ordered by a licensed physician or surgeon
 - e. Feeding must conclude 30 minutes before transportation commences
12. Are there any instances in which the feeding should be held/not administered? Please explain. _____

I, the undersigned as the physician for the above-named student do recommend and approve the above-named procedure(s) to be provided to this pupil during school hours. This order should be in effect for a maximum of one year, unless specified otherwise:

Signature of Physician: _____ Date: _____

Printed name (or stamp) of Physician: _____ Phone number: _____