

HEALTH CARE PROVIDER AUTHORIZATION AND RECOMMENDATIONS FOR MIC-KEY GASTROSTOMY (G) OR GASTROJEJUNOSTOMY (GJ) TUBE FEEDING

Student's name: _____ Birthdate: _____

School: _____ Grade: _____

Student's diagnosis: _____

Type of feeding tube: ☐ G ☐ GJ ☐ Mic-Key

This is to certify that the above named student is under my care and needs to receive gastrostomy or gastrojejunostomy tube feedings during schools hours as ordered below. I understand that some of these feedings may be administered by medically unlicensed school staff that will be trained and monitored by a school nurse.

GASTROSTOMY OR GASTROJEJUNOSTOMY TUBE FEEDING(s)

Times(s) to Administer	Type and Amount of formula, juice, milk	Amount of water	Rate to Feed (as bolus over "X" minutes or as continuous feed over "X")
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please note position of student: During feeding _____
 After feeding _____

Precautions, possible complications, and recommended interventions. (Note that school staff do not reinsert G or GJ tubes.)

Other comments:

Beginning date for order: _____ Ending date for order: _____

Provider's signature: _____ **Office #:** _____

Provider's printed name: _____ **Fax #:** _____

Office address: _____

