

**PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for
Management of a Feeding Tube in Educational Settings and Sponsored Events**

Student:	DOB:	Date:
District/Site:	Teacher/Rm:	Grade:

1. Latex Allergy: ☐ YES ☐ No 2. Type of feeding tube: ☐ G-tube ☐ G-J tube ☐ J-tube ☐ PEG-J tube 3. Type of device: ☐ MIC-KEY™ ☐ Foley - adjust. Length _____ ☐ Mini-ONE® ☐ NG - adjust. Length _____ ☐ Bard ☐ Other: _____ Size: _____ 4. Tube Feeding: Time(s) of feeding: _____ Formula: _____ Amount/feeding: _____ Water– Amount before feeding: _____ Amount after feeding: _____ Other: _____ Feeding method: ☐ Bolus – duration of feeding: _____ ☐ Gravity - bag height: _____ ☐ Pump - rate: _____ Student's position during feeding: _____ 5. Residual: ☐ NOT necessary ☐ Check before every feeding ☐ Hold feeding if residual > _____ Additional instructions: _____ 6. Medication administered via g-tube at school: ☐ No ☐ Yes (medication authorization(s) attached)	7. Decompression: ☐ NOT needed ☐ Before feeding ☐ After feeding ☐ During feeding ☐ PRN signs/symptoms: _____ Duration of decompression: _____ 8. If gastrostomy tube becomes dislodged: ☐ Cover site and notify parent. ☐ Use a catheter to maintain temporary ostomy patency by RN/LVN/UAP (unlicensed assistive personnel). ☐ Insert gastrostomy tube by RN/LVN/UAP. ☐ Insert skin-level button by RN/LVN/UAP. ☐ Other: _____ Reinsertion must occur within: _____ 9. Fundoplication: ☐ No ☐ Yes, date: _____ 10. Oral feedings: Feeding evaluation: ☐ No ☐ Yes (copy attached) ☐ NPO (nothing by mouth) ☐ Tiny tastes of food/liquids ☐ Thin liquids (e.g., formula, milk, juices, water, popsicle) ☐ Thick liquids (e.g., nectar, milkshake, ice cream, yogurt, thickened juices) ☐ Thickener: _____ Amount: _____ ☐ Pureed foods (e.g., applesauce) ☐ Other: _____ 11. Other pertinent information or recommendations:
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Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization. Authorizations may be faxed.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

☐ I request that the credentialed school nurse provide me with a copy of the completed Individualized Health-Care Plan (IHP).

**PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for
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Student:	DOB:	Date:
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Authorization for Trained Unlicensed Person

Feeding may be performed by a trained unlicensed person. ☐ Yes ☐ No

Medication administration via feeding tube may be performed by a trained unlicensed person. ☐ Yes ☐ No

Health-Care Provider Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.

I (we) understand that I (we) will be provided a copy of my child's completed Individualized Health-Care Plan (IHP).

Parent(s)/Guardian(s) Signature: _____ Date _____

_____ Date _____

Reviewed by credentialed school nurse (signature) _____ Date _____

☐ Credentialed school nurse has informed principal about health-care services provided for this student.