



ESCAMBIA COUNTY PUBLIC SCHOOLS
HEALTH SERVICES
J. E. Hall Center 30 E. Texar Dr.
Pensacola, FL 32503
Phone: (850) 469-5456

AUTHORIZATION FOR ADMINISTRATION OF GASTROSTOMY/JEJUNOSTOMY TUBE FEEDINGS

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each section must be completed by the appropriate person. Part I and III by Parent/Guardian. Part II by Physician.
Please return the completed form to the school clinic.

I. INFORMATION (To Be Completed By Parent/Guardian).

PLEASE FILL IN COMPLETELY

Student's Name (Last, First, Middle)		Birth Date	Allergies	Grade/Homeroom Teacher
Parent/Guardian		Address		
Home Phone	Work Phone		Cell Phone	

II. Procedure/Treatment Plan (To Be Completed By Physician).

PLEASE FILL IN COMPLETELY

Reason for Procedure/Treatment: _____ Time for Procedure/Treatment: _____ A.M. _____ P.M.

☐ Continuous feeding from _____ to _____ (may disconnect/reconnect for short periods to accommodate school schedule.)

☐ Keep head elevated _____ degrees during and for _____ minutes after feeding

Check tube placement prior to feeding: ☐ No ☐ Yes Specific instructions: _____

Check residual: ☐ No ☐ Yes If residual is greater than _____ do not feed for _____ minutes ☐ Check bowel sounds

Venting: ☐ No ☐ Yes Specific instructions: _____

☐ Gastrostomy Feeding: ☐ Bolus ☐ Gravity ☐ Pump Type of Pump: _____ Flush with _____ cc water

☐ Jejunostomy Feeding: ☐ Gravity ☐ Pump Type of Pump: _____ Flush with _____ cc water

Type of Formula: _____

Volume: _____ ml/cc Rate: _____ ml/cc per hour

Student specific instructions for Procedure/Treatment: _____

Student specific precautions, possible complications, and recommended interventions: _____

Print Physician's Name:

Physician's Address:

Phone:

Physician's Signature:

Date:

III. PARENTAL PERMISSION (To Be Completed By Parent/Guardian).

I hereby request the school's personnel, or its agents to provide the above medication, procedure and/or treatment to my child. I give permission for my child to receive this medication, procedure/treatment while participating in a school-sponsored field trip away from the school site. I understand that there is no liability on the part of the school district, its personnel, or its agents, for civil damages as a result of the administration of medication and/or procedure/treatment to my child when the person administering the medication(s) or performing the procedure/treatment acts as an ordinarily reasonably prudent person would have acted under the same similar circumstances. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel of the Escambia County Public Schools or its agents.

Parent/Guardian Signature: _____ Date: _____