| *Attach Photo* | **Tube Feeding Authorization Form**<br>This order is valid only for the current school year _____ (Including summer school)<br>**OR**<br>Start Date: _____/_____/_____ to Stop Date: _____/_____/_____<br>This treatment authorization form must be completed fully in order for staff to administer required treatment.<br>A new form must be completed at the beginning of each school year<br>* Carefully review the reverse side of this form before completion * |
|---|---|

| *Name of Student:* | *Date of Birth:* | *Grade:* |
|---|---|---|

## HEALTH CARE PROVIDER AUTHORIZATION

| Reason for Treatment: | Allergies: | | |
|---|---|---|---|
| Method of Infusion: | Time of Administration: | Type of Solution: | Route: |
| ☐ Pump Rate:_____ Volume: _____<br>☐ Gravity Volume: _____ over _____ minutes<br>☐ Bolus Volume: _____ over _____ minutes | | | ☐ Gastrostomy Tube<br>☐ Jejunostomy Tube |

***Flush feeding tube with _____ cc of water and disconnect after feeding is complete.***

***Treatment instructions:*** (only a RN/LPN can reinsert a gastrostomy device)

If gastrostomy device is dislodged, the registered nurse will:
Insert new gastrostomy device size _____ fr & _____ cm
Utilize water soluble lubricant or water to facilitate reinsertion of device. Inflate balloon with directed amount of water.
If the nurse is not available or if the tube cannot be reinserted, maintain stoma patency by:
_____

***Additional Instructions:***

| ***Is student competent to self-administer treatment?*** Yes No | *Health Care Provider Stamp* |
|---|---|
| ***Health Care Provider's Name/Title:*** (please print) | |
| Telephone: Fax: | |
| Address: | |

***Health Care Provider's Signature:*** ***Date:***

## PARENT/GUARDIAN AUTHORIZATION

I request designated personnel to administer the treatment as prescribed by the health care provider above. I certify that I have legal authority to consent to the administration of treatment at school and understand that the health care provider will be contacted if questions arise regarding the student's treatment order.

| ***Primary Contact Phone:*** | ***2nd Phone:*** |
|---|---|

***Parent/Guardian Signature:*** ***Date:***

## REGISTERED NURSE REVIEW / AUTHORIZATION

***Is the student competent to self-administer treatment?*** Yes No

***Registered Nurse Signature:*** ***Date:***

A verbal order was taken by the school RN (name) _____ for the above medication on (date) _____
Verbal order must be followed by a signed order within 1 day.

# IMPORTANT INFORMATION

## For Parents/Guardians and Health Care Providers

1. Please give your child any needed treatment at home if at all possible.

2. It is recommended that the first full day's (24 hours) treatment be given at home. If unsure, follow the recommendation of the health care provider about attending school during the first 24 hours.

3. Parent/guardian responsibilities:
   a. Provide and maintain all equipment and supplies for the duration of the treatment order.
   b. The parent/guardian must provide new supplies prior to the expiration date(s).

4. The parent/guardian or student may demonstrate how to administer the treatment to the staff person who will monitor or administer the treatment and provide information regarding potential adverse effects.

5. Student Self-Administer Treatment:
   a. The health care provider and registered nurse must indicate whether the student is competent to self-administer treatment, if needed.
   b. If competent to self-administer, the registered nurse will work with the student and parent/guardian to develop guidelines to self-administer feeding and include guidelines in the student's individual care plan.

6. The registered nurse must review and approve the form prior to administration.