G-TUBE FEEDING TREATMENT AUTHORIZATION FORM

Instructions: This form is to provide medical and parental authorization for Tube feeding treatment to be provided during school hours. Both the Physician and Parent/Legal Guardian portions of this authorization form must be completed entirely, signed, and returned to the school before the treatment may be administered.

Student's Name	Sex	Date of Birth	Grade

School _____ Phone Number(s) _____ FAX Number _____

The following section is to be completed by the prescribing Physician:

The student named in this document is under the medical supervision for the diagnosis described below. I have prescribed the following treatment, which is necessary to be given in school. I am aware that this physician prescribed service may be administered by non-medically trained staff.

Diagnosis for which tube feeding will be required in school:			
Allergies:			
Type of Gastrostomy ☐ PEG ☐ Button ☐ G-Tube ☐ Other (describe) Appliance placed:			
Tube feeding formula:		Amount of tube feeding:	
Tube flush:		Amount of tube Flush solution:	
Time and frequency of feedings:			

Is it necessary to Measure residual Stomach contents? ☐ No ☐ Yes

If yes, will the residual content alter feeding volume? ⇨ ☐ No ☐ Yes

If yes, please indicate the residual amount that would prohibit feeding at the prescribed time: ____ cc total volume.

Tube feeding method:
- ☐ Bolus by gravity
- ☐ Bag
- ☐ Syringe
- ☐ Mechanical Pump
  - Type of pump _____
  - Rate of flow _____cc/hr.

Physician's name: _____ Phone number: _____

Physician's address: _____

Physician's signature: _____ Date: _____