

ENTERAL FEEDING AUTHORIZATION

STUDENT:	SCHOOL:	GRADE:	DOB:
ADDRESS:		STATE:	ZIP:
MEDICAL HISTORY:			

TO BE FILLED OUT OR REVIEWED BY THE PRESCRIBING PRACTITIONER:
☐ **G-Tube feeding** ☐ **Jejunostomy feeding** ☐ **Other** _____

☐ **Continuous** ☐ **Intermittent** ☐ **Bolus** ☐ **Pump**
Feeding fluid type _____ **Rate** _____ **Volume** _____ **Time(s)** _____

Flush with _____ **ml water** ☐ **before and** ☐ **after feedings**
☐ **Hydrate with** _____ **ml water or** _____ **Time(s)** _____

Medical Procedure(s):

1. Nurse may replace g-tube if needed.

PRESCRIBING PRACTITIONER AUTHORIZATION: *I have determined that the above described medical procedure is medically necessary during school hours to maintain this child's physical health.*

Practitioner Signature: _____ **Date:** _____

Office Phone: _____ **Fax Number:** _____

PARENT/GUARDIAN AUTHORIZATION: *The school authorized personnel has my permission to administer the above Medical Procedure. I will also adhere to the following conditions of this agreement:*

1. I will bring this form into the office completed and signed by my health practitioner before expecting this medical procedure to be completed at school.
2. I understand that school personnel may not perform the medical procedure until training by the school nurse is completed.
3. I will maintain the supplies needed for this procedure throughout the year
4. I will renew this authorization every time there is a change of any kind regarding the medical procedure.

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

Home Phone: _____ **Emergency Phone:** _____

