Hays CISD Enteral Feeding and Treatment Authorization Form

Student's Name	Sex	Date of Birth	Student #
School		Grade	

This form provides professional and parental authorization for medical treatment to be provided during school hours. Both the prescribing physician or health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Physician's Statement:

The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment that is necessary to be provided during school hours for the child's health and/or safety. I am also aware that the prescribed treatment (except re-insertion of the G-button) may be administered by a trained non-medical personnel in the classroom.

If the G-button was to become dislodged requiring re-insertion:

☐ I confirm the student named in this document has an established tract, that if needed may be accessed by a parent/guardian, trained RN/LVN, or Parent/Guardian Designated & Trained Emergency Contacts.

Physician's Order:

Type of gastrostomy appliance placed: Peg _____ Button _____ G-Tube _____ Other, describe _____			
Date of initial tube/device insertion:		Tube/Device size (Fr and cm):	Volume of water in balloon (mls)
Type of water to fill balloon:	Tap water/Other:		
Method for verifying placement (if applicable):			
Placement verification frequency (if applicable):			
Type of tube feeding:		Amount:	
Type of tube feeding flush:		Amount:	
Time and frequency of feedings:			
Is it necessary to measure residual stomach contents? Yes_____ No _____ If yes, will the residual content alter feeding volume? Yes _____ No _____ 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 _____ If Mechanical pump – Type of pump _____ Rate of flow _____ If pump malfunctions may do bolus feeding Yes_____ No_____			
Is student allowed oral feedings? Yes _____ No _____ If yes, Type: _____ Frequency: _____			

Physician's Name (Print) _____ Phone #_____ Fax # _____

Physician's Signature _____ Date_____

Parent/Legal Guardian Consent to Treatment

The following section is to be completed by the parent/legal guardian:

- ☐ I consent to the campus nurse and trained campus staff at_____ school to assist in the administration of the above prescribed treatment to my child while in school and away from school while participating in official school activities.
- ☐ I give consent for my child's doctor to be contacted for information regarding the administration of the treatment listed on this form.
- ☐ I understand that it is my responsibility to notify and provide a new completed form to the school when these orders change.
- ☐ I also understand these orders are valid for 1 school year.
- ☐ I agree to provide all treatment supplies.
- ☐ I will pick up all supplies on or before the last day of school or allow the school to discard them, if not picked up.

If my child's G-Button is dislodged or removed:

- ☐ I **DO** give consent for a trained campus RN, LVN if supervising RN is on campus, or Parent/Guardian Designated & Trained Emergency Contacts to re-insert my child's G-button. Please complete & sign the *G-button Reinsertion to Prevent Closure of Stoma Guideline, Consent & Trained Emergency Contacts* form so we know who we can contact them to check placement after replacement.
- ☐ I **DO NOT** give consent for a trained campus RN, LVN if supervising RN is on campus, or Parent/Guardian Designated & Trained Emergency Contacts to re-insert my child's G-button. If it becomes dislodged, please cover the site, contact me immediately so I may seek medical attention and direction for my child.

Parent/Guardian Name (Print) _____ Phone #_____ Work # _____

Parent/Guardian Signature _____ Date _____