PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of a Feeding Tube in Educational Settings and Sponsored Events

School Year:

This authorization is valid for the current school year only

Student:	**DOB:**	**Date:**
District/Site:	**Teacher/Rm:**	**Grade:**

1. **Latex Allergy:**
   - ☐ YES
   - ☐ No
2. **Type of feeding tube:**
   - ☐ G-tube ☐ G-J tube
   - ☐ J-tube ☐ PEG-J tube
3. **Type of device:**
   - ☐ MIC-KEY™ ☐ Foley - adjust. Length _____
   - ☐ Mini-ONE® ☐ NG - adjust. Length _____
   - ☐ Bard ☐ Other: _____

   Size/length: _____
4. **Tube Feeding:**

   Time(s) of feeding: _____

   Formula: _____ Amount/feeding: _____

   Water: Amount before feeding: _____

   Amount after feeding: _____

   Other: _____

   Feeding method:
   - ☐ Bolus - duration of feeding: _____
   - ☐ Gravity - bag height: _____
   - ☐ Pump - rate: _____

   Student's position during feeding: _____
5. **Residual:**
   - ☐ NOT necessary
   - ☐ Check before every feeding
   - ☐ Hold feeding if residual > _____

   Additional instructions: _____
6. **Medication administered via g-tube at school**:

   ☐ No ☐ Yes (medication authorization(s) attached)
7. **Decompression**:
   - ☐ NOT needed
   - ☐ Before feeding ☐ After feeding ☐ During feeding
   - ☐ PRN signs/symptoms: _____

   Duration of decompression: _____
8. **If gastrostomy tube becomes dislodged:**
   - ☐ Cover site and notify parent.
   - ☐ Use a catheter to maintain temporary ostomy patency by RN/LVN/UAP (unlicensed assistive personnel).
   - ☐ Insert gastrostomy tube by RN/LVN/UAP
   - ☐ Insert skin-level button by RN/LVN/UAP
   - ☐ Balloon volume:_____ml
   - ☐ Reinsertion must occur within:_____mins
9. **Fundoplication:** ☐ No ☐ Yes, date: _____
10. **Oral feedings**:

    Feeding evaluation: ☐ No ☐ Yes (copy attached)
    - ☐ NPO (nothing by mouth)
    - ☐ Tiny tastes of food/liquids
    - ☐ Thin liquids (e.g., formula, milk, juices, water, popsicle)
    - ☐ Thick liquids (e.g., nectar, milkshake, ice cream, yogurt, thickened juices)
    - ☐ Thickener: _____ Amount: _____
    - ☐ Pureed foods (e.g., applesauce)
    - ☐ Other: _____
11. **Other pertinent information/recommendations**:

    _____

    _____

    _____

    _____

    _____

Authorized Health-Care Provider Authorization for Management in the Educational Setting

My signature below provides authorization for the above written orders. I understand all procedures will be implemented in accordance with state laws and regulations.

_____ (Initial here) I authorize unlicensed designated school personnel, under the training and supervision provided by the credentialed school nurse, may provide this procedure. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization.

***Authorized Health-Care Provider Name** _____ ***NPI Number** _____

Signature _____ **Date** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

Supervising Physician Name _____ **NPI Number** _____

Phone _____ **Address** _____ **City** _____ **Zip** _____

PARENT CONSENT AND AUTHORIZED HEALTH-CARE PROVIDER AUTHORIZATION for Management of a Feeding Tube in Educational Settings and Sponsored Events

Student:	DOB:	Date:

Authorization for Trained Unlicensed Person

Feeding may be performed by a trained unlicensed person. ☐ **Yes** ☐ **No**

Medication administration via feeding tube may be performed by a trained unlicensed person. ☐ **Yes** ☐ **No**

Health-Care Provider Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Parent Consent for Authorization and Management in the Educational Setting

I (we) the undersigned, the parent(s)/guardian(s) of the above-named student, request that the specialized physical health-care service be administered to my (our) child in accordance with state laws and regulations.

I (we) will:

1. provide the necessary supplies and equipment;
2. notify the credentialed school nurse if there is a change in child's health status or attending authorized health-care provider; and
3. notify the credentialed school nurse immediately and provide new written consent/authorization for any changes in the above authorization.

I (we) give consent for the school nurse to communicate with the authorized health-care provider when necessary.

Parent(s)/Guardian(s) Signature: _____ **Date** _____

_____ **Date** _____

Reviewed by credentialed school nurse (signature) _____ **Date** _____