# Wasatch County School District
# Tube Feeding/Treatment Authorization Form

| Student's Name | Date of Birth | Bus ___Yes ___ No |
|---|---|---|
| School | School Year | Fax Number |

***This form provides health care provider and parental authorization for medical treatment to be provided during school hours. Both the prescribing health care provider and the parent/legal guardian are required to complete this document before the services can be provided. Any alteration of the form invalidates the authorization.***

**Note:** Physician's orders are required for ***all medical procedures administered at school.*** Please have your child's physician complete this portion of the form and return it to the school or have them fax it to the school nurse FAX: 435-200-1032

**The following section is to be completed by the prescribing physician or health care provider:**
**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 given during school hours for the child's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.**

| | |
|---|---|
| Diagnosis for which tube feeding will be required in school: | |
| Allergies: | |
| Type of gastrostomy appliance placed: ☐Peg ☐Button ☐G-Tube ☐Other, describe: | |
| Type of tube feeding formula: | Amount: |
| Type of tube feeding flush: | Amount: |
| Time and frequency of feedings: | |
| Feeding/Positioning Instructions: | |
| Is it necessary to measure residual stomach contents? ☐Yes ☐No **If yes**, will the residual content alter feeding volume? ☐Yes ☐No<br>**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 ☐if pump malfunctions may do bolus feeding<br>☐Mechanical pump – Type of pump Rate of flow: | |
| Is student allowed oral feedings? ☐Yes ☐No If yes, Type: Frequency: | |
| If medications are administered per gastrostomy, specify type: Dose: Time: | |
| Any Special Instructions for administering medication? | |
| Amount of flush post medication administration: | |

## Stoma Preservation Plan

In the event the g-tube comes out or is dislodged, check all that apply:

☐School nurse or trained personnel will preserve the stoma (health care provider to enter instructions for stoma preservation)

_____

☐Notify parent immediately for reinsertion and verification of placement prior to use for feeding.

☐Notify provider immediately

Physician's Name (Print):_____Phone Number:_____

Physician's Signature:_____Date:_____Fax Number: _____

School Nurse's Signature:_____Date: _____

## Parent/Legal Guardian Consent

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

I authorize this procedure to be performed by the school nurse or the nurse's delegatee as directed above. I agree to provide the needed supplies for the procedure and understand that new forms must be completed annually or with any changes in the student's health status. By signing this document, I give permission for the nurse or nurse designee to administer this procedure as prescribed and give my permission for this Health Care Provider to share information about this procedure with the Registered Nurse or nurse designee. The undersigned parent(s) or guardian(s) hereby agree(s) to exempt and release Wasatch County School District and its directors, officers, employees, volunteers and agents, from any and all liability, claims, demands or actions whatsoever arising out of any damage, loss or injury that my child or I/we might sustain or which they now have or may hereafter have arising out of the administration of this procedure. Should the G-Tube become dislodged, I will be immediately contacted by school personnel. I will provide all necessary treatment supplies and will pick the supplies up on the last day of school.

| | | |
|---|---|---|
| Parent/Guardian Name: | | Relationship: |
| Home phone: | Business phone: | Emergency phone: |
| Parent/Guardian Signature: | | Date: |

REV Sep. 2018