Authorized Healthcare Provider's Authorization and Parent Consent Form for Management of Gastrostomy Feeding in School and School Sponsored Activities

First Name: **M.I:** **Last Name:**

DOB: **School:** **Grade:**

1. **Type of Feeding Device:**
   - ☐ Gastrostomy tube: Type _____
     Size _____ Adjusted tube length _____
   - ☐ Gastrostomy Button:
     - ☐ MicKey
     - ☐ Bard
     - ☐ Other _____
   - ☐ Jejunostomy Tube: Type _____
     _____
     Size _____ Fr _____ cm
2. **Fundoplication:**
   ☐ Yes, Date _____ ☐ No
3. **Formula feeding:** _____
   Amount _____
   Time _____
4. **Feeding method::**
   - ☐ Syringe
   - ☐ Slow-drip from bag: Rate: _____
   - ☐ Drip from pump: Rate: _____
   - ☐ Protable pump: Rate: _____
5. **Residual:**
   - ☐ Check residual
   - ☐ Residual check not necessary
   - ☐ Feed if residual < _____
   - ☐ Hold feeding if residual > _____

   Further instructions:
   _____
   _____
6. **Water:**
   Amount before feeding _____
   Amount after feeding _____
   Other _____
7. **Decompression:**
   ☐ Yes ☐ No ☐ PRN
   Signs and Symptoms _____
   Length of time for decompression _____
8. **Authorized Medication(s) to be administered through Gastrostomy:**
   Name of medication _____
   Dose _____ Time _____
   Name of medication _____
   Dose _____ Time _____
9. **In the event the gastrostomy tube/button becomes dislodged:**
   - ☐ Cover site and notify parent
   - ☐ Reinsert gastrostomy tube
   - ☐ Reinsert Skin level Button
   - ☐ Other _____

   Reinsertion must occur within: _____
10. **Oral feedings**:
    Feeding Evaluation: ☐ Yes copy attached ☐ No
    - ☐ NPO (nothing by mouth _____)
    - ☐ Tiny tastes of food/liquids
    - ☐ Thin liquids: i.e. formula, milk, juices, water, popsicles
    - ☐ Thick liquids: i.e. nectar, thick milk shakes, ice cream, yogurt, thickened juices
    - ☐ Thickener _____ Amount _____
    - ☐ Pureed foods (i.e., applesauce)
    - ☐ Other _____
11. **Please list any signs or symptoms that may indicate an emergency situation:**
    _____
    _____
12. **Other:** _____
    _____

Authorized Health Care Provider Authorization For Management of Gastrostomy Feeding In School

My signature below provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of one year. If changes are indicated, I will provide new written authorization (may be faxed).

Authorized Healthcare Provider Name: _____ **Signature** _____

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

☐ I request that the School Nurse provide me with a copy of the completed Individualized School Healthcare Plan (ISHP).

Parent Consent for Management of Gastrostomy Feeding in School

I (we) the undersigned, the parent(s)/guardian(s) of the above named pupil, request the authorized specialized physical health care service for Management of Gastrostomy Feeding in school 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 school nurse if there is a change in pupil health status or attending authorized healthcare provider.
3. Notify the school nurse immediately and provide new consent for any changes in authorized healthcare provider's orders,

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

I (we) understand that I (we) will be provided a copy of my child's completed Individual School Healthcare Plan. (ISHP)

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

_____ **Date**_____