Authorization to Administer G-Tube Feeding and/or Water

All specialized health services/procedures will be administered by a licensed school nurse or other qualified school personnel who have been trained by the school nurse to administer the service/procedure under the indirect supervision of the school nurse. The purpose is to ensure that students receive necessary therapeutic interventions according to their provider's orders while maximizing safety. Please see separate Provider Authorization for medication administration via gastrostomy if applicable.

Student Name: _____ Student No: _____
DOB: _____

HEALTHCARE PROVIDER'S STATEMENT:

Medical Diagnosis: _____ ICD-10 Code(s):_____

Service or Procedure to be provided (check all that apply): ☐ Feeding ☐ Water Feeding instruction:

_____ Type of formula Volume

Frequency Rate

Water instruction: _____

Volume Frequency

In the event the G-tube is pulled out or is dislodged (check all that apply):

☐ School nurse or trained personnel should replace the tube. The nurse must verify placement before feeding, water or medication is administered

☐ Notify parent immediately

☐ Notify provider immediately

☐ Other: _____

Provider's signature: _____ Date: _____

Provider's name (printed):_____ Phone: _____

Address: _____ Email: _____

Parent/Guardian Statement

I/We, the undersigned parent(s)/guardian(s) of _____hereby request the school nurse or designee administers the above procedure according to the provider's instructions. I/We agree to furnish all equipment, supplies, medication, formulas, or other necessary items for the administration of the service or procedure and to provide replacement and maintenance as necessary. I/We agree to notify the school nurse immediately if there is any change in the student's status or provider orders. Implementation of these orders and care includes authorization to contact the healthcare provider to discuss this procedure and elements of care needed for this condition. Without this authorization these orders will not be implemented.

Signature: _____ Date:_____

Signature: _____ Date:_____

Primary phone: _____ Secondary phone: _____ Other:_____

School Nurse Signature: _____ Date: _____