

MIDLAND SCHOOL

TUBE FEEDING AUTHORIZATION FORM

This order is valid only for the current school year: 2016-2017

This treatment authorization form must be completed fully in order for staff to administer required treatment. A new form must be completed at the beginning of each school year.

Name of Student: Date of Birth: Teacher:

HEALTH CARE PROVIDER AUTHORIZATION

Allergies:

Condition for which treatment is being administered:

Method of Infusion: Type of Solution: Route: Feeding Tube

Flush feeding tube with cc of water and disconnect after feeding complete.

Time(s) of Administration: If PRN, frequency:

School Nurse may replace tube if becomes dislodged during the school day: Y N

Parent/Guardian may withhold feeding for school activities (i.e. field trips) with written notification to the nurse? Yes No

Is student competent to self-administer treatment? Health Care Provider's (Please Print) Name/Title: Telephone: Fax: Address: Health Care Provider Stamp

Health Care Provider's: Signature Date:

PARENT/GUARDIAN AUTHORIZATION

I request the school nurse to administer the treatment as prescribed by the health care provider above. I agree to furnish all equipment, supplies and medications necessary for treatment. I give permission to the school nurse to re-insert the G-tube if it becomes dislodged during the school day.

Primary Contact Phone: Email:

Parent/Guardian Signature: Date:

MIDLAND SCHOOL RN REVIEW/AUTHORIZATION

Is student competent to self-administer treatment? Yes No

Midland School Nurse Signature: Date:

