Health Services

Primary Care Provider Authorization for Gastric Tube Feeding

Student: ____ Date of Birth: _______________________

School: ____ School Year: _______________________

Type of Feeding Tube:

- ☐ Gastric — Specify Type: ____
- ☐ NG (Nasogastric) — Specify Type: ____
- ☐ GJ (Gastrojejunal) — Specify Type: ____
- ☐ Other — Specify Type: ____

Formula to be Given:

Name of formula: ____

(Feeding formula must be unexpired and sent to school in original unopened container)

Specific Feeding Times During School Day: ____

(Please write the actual time in hours and minutes)

Delivery Method:

☐ **Pump:**

Type of pump: ____

Total volume to be given: ____

Flow Rate: __________________________cc / ml over _______________________ minutes

(Note: In case of pump malfunction please specify below if gravity feed is to be given instead)

☐ **Gravity feeding via:**

- ☐ Syringe
- ☐ Bag

Total volume to be given: ____

Amount of time to be given over: ____ minutes

Volume of Water to Administer (Flush) Following Feeding: ____________________________________ cc / ml

Additional Health Care Provider Instructions:

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________________________________ ____

Printed Name of Heath Care Provider **Address**

________________________________ ____________________________ __________________________

Signature of Health Care Provider **Phone Number** **Date**

Note to Parent / Guardian: Signing this form shall release the Allen Independent School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.

________________________________ ____________________________ __________________________

Signature of Parent / Guardian **Emergency Contact Number** **Date**

Health Services 5/2019