Carroll County Public School

Attach Photo	**Tube Feeding Authorization Form** This order is valid only for the current school year _____ (Including summer school) **OR** Start Date: _____/_____/_____ to Stop Date: _____/_____/_____ 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 and with any changes in health care provider orders * Carefully review the reverse side of this form before completion *

Name of Student:	*Date of Birth:*	*Grade:*

HEALTH CARE PROVIDER AUTHORIZATION

Reason for Treatment:	Allergies:		
Method of Infusion:	Time of Administration:	Type of Solution:	Route:
☐ Pump Rate:_____ Volume: _____ ☐ Gravity Volume: _____ over _____ minutes ☐ Bolus Volume: _____ over _____ minutes			☐ Gastrostomy Tube ☐ Jejunostomy Tube ☐ Nasogastric Tube

Flush feeding tube with _____ ml of water and disconnect after feeding is complete.

Treatment instructions: (only a RN/LPN can reinsert a gastrostomy device)

If gastrostomy device is dislodged, the nurse will:
Insert new gastrostomy device size _____ fr & _____ cm or cover with dry sterile gauze and notify parent_____
If parent does not arrive within _____ minutes call 911
Utilize water soluble lubricant or water to facilitate reinsertion of device. Inflate balloon with directed amount of water.
If the nurse is not available or if the tube cannot be reinserted, maintain stoma patency by: _____
Extension tubing change frequency:_____
Bag change frequency:_____
Bag/extension tubing will be changed more frequently at the nurse's discretion

In case of pump failure:

Venting Orders:

Is student competent to self-administer treatment? Yes No

Health Care Provider's Name/Title: (please print)

Telephone: Fax:

Address:

Health Care Provider's Signature: ***Date:***

Parent/Guardian Signature: ***Date:***

SCHOOL NURSE REVIEW / AUTHORIZATION

Is the student competent to self-administer treatment? Yes No

School Nurse Signature: ***Date:***