



## Treatment Authorization Form- Feeding Tubes

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ School Year: \_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_

### Authorization for administration of health treatment and/or medication at school.

- This authorization is only valid for the current school year beginning \_\_\_\_\_ and ending \_\_\_\_\_. An authorization form must be completed at the beginning of each school year, for each treatment, and each time there is a change in treatment orders.
- Parents are urged to provide health treatments at home and on a schedule other than school hours, if possible.
- Tube feedings, or medications prescribed for administration through a feeding tube, must be in the original container labeled by the pharmacist or prescriber.
- Non-prescription feedings or medications must be in the original container with the factory label intact.
- Any medical supplies needed to carry out the following treatment must be provided by the parent/guardian.
- The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

### Health Care Provider Instructions

#### Feeding Tube Type:

- Gastrostomy Tube       Gastrostomy and Jejunostomy Tube       Jejunostomy Tube

#### Instructions for Administration of Feedings and/or Medications via

- Gastrostomy       Jejunostomy
- Position student upright or semi-reclining with head at least \_\_\_\_\_ degrees during feeding AND/OR
- Keep student upright for \_\_\_\_\_ minutes after feeding

Feed: \_\_\_\_\_

Name of Feeding to be Administered      Volume to be Fed

Parents/guardians may provide adjustments to feeding/flush/free water amounts within the following parameters. Changes must be provided to school staff in writing.

#### Frequency:

- Continuous: \_\_\_\_\_
- Specify Rate      Time(s) Feeding Administered
- Intermittent- Gravity Fed over \_\_\_\_\_       Intermittent via pump \_\_\_\_\_
- Specify Time      Specify Rate
- Check for residuals. If residual greater than \_\_\_\_\_ mL:
- Feed     Do not feed- notify parent     Delay feeding for \_\_\_\_\_ minutes and recheck residual
- Other: \_\_\_\_\_
- Administer free water \_\_\_\_\_
- Volume mL      Time(s) / Frequency
- Flush tube with water       Before feeding or medications with \_\_\_\_\_ mL
- After feeding or medications with \_\_\_\_\_ mL
- Do not flush tube with water

#### Additional

Instructions: \_\_\_\_\_

**Gastrostomy and/or Jejunostomy Care in School**

If gastrostomy tube becomes dislodged:

Nurse or trained school staff may reinsert gastrostomy tube within \_\_\_\_\_ for patency.

*If checked, trained school staff may reinsert with direct supervision of an RN* Minutes

Re-insert displaced tube  Insert new gastrostomy tube  Insert foley catheter with balloon

Notify parent/guardian immediately

*Note: Gastrostomies may NOT be used in school after dislodgement until parents have had tube replaced with placement confirmed according to provider instructions. Nurses may not replace and confirm placement except for special cases, which require administrative approval and additional instructions from the student's provider.*

If gastrostomy with jejunostomy or jejunostomy becomes dislodged, tube must be placed by a provider and:

Notify parent/guardian immediately to contact provider

Cover with 4x4 gauze and tape

Nurse or trained school staff may reinsert gastrostomy tube within for patency Minutes

Instructions if gastrostomy or jejunostomy port becomes clogged:

Notify parent/guardian immediately

Administer prescribed enzymatic de-clogging

Agent: \_\_\_\_\_

Agent & Instructions

*"Home remedy" De-clogging substances (i.e. cola) and excessive force are not approved for use in de clogging ports by nurses and trained school staff.*

Additional Gastrostomy and/or Jejunostomy Instructions (i.e. dressings):

\_\_\_\_\_  
\_\_\_\_\_

**Note to Prescriber:** *Please consider ordering additional supplies and medications to be kept at school (i.e. tubing, syringes, replacement tubes, etc.)*

**Prescriber's Printed Name/Title** \_\_\_\_\_ **Prescriber's Signature** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date

Telephone

Fax

**Parent/Guardian Authorization**

I/we request designated school personnel to provide the treatments in this document as prescribed by the above. I/we certify that I/we have legal authority to consent to medical treatment for the student named above. I/we understand that at the end of the school year, an adult must pick-up any medications and medical supplies, otherwise they will be discarded. I/we authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Daytime Contact Number: \_\_\_\_\_

Fax: \_\_\_\_\_

Order/Authorization Reviewed by School RN: \_\_\_\_\_

Signature

Date

Revised 7/11/2022

Adapted from Michigan Department of Education Administration of Medication in Schools Model School Nurse Guideline (2014)