PHYSICIAN AUTHORIZATION FOR SPECIAL PROCEDURE:
GASTROSTOMY TUBE FEEDING DURING SCHOOL HOURS

STUDENT:_____ Gr:_____ DOB:_____

Physician instructions regarding G-tube feeding:

1. Student is to receive G-tube feeding via: · ***Gravity*** · ***Pump*** *(select applicable response)*

2. Student's condition requiring G-tube feeding:_____

3. Student should be fed with head/upper body elevated at a _____degree angle and should remain upright for _____ minutes after feeding.

4. Feeding schedule **during school hours** *(times may vary up to ½ hour to meet school schedule):*

Time:	***Formula/Solution Name:***	***Quantity to be fed*** *(specify in cc's):*	***Rate/Duration of feeding:***	***Flush tubing with water after feeding*** *(specify in cc's)*	***Additional Info:***

5. Student has had a **Nissan** Fundoplication? _____**Yes** _____**No**

6. Is student allowed oral feeds in addition to G-tube feeds? _____**Yes**_____**No**

   If yes, please specify consistencies, amounts, and feeding precautions. _____
   _____

7. Has student had a recent swallow study? _____Yes_____No

   If yes, when and what were the results?_____
   _____

   Please provide a copy of the physician report of the swallow study to the School Nurse

_____ _____ _____
Physician Signature *Physician Name (PRINT)* *Date*

_____ _____
Office Telephone Number *Office Address*

_____ _____
Parent Signature *Date*