Washington County School District Health Services

ENTERAL FEEDING AUTHORIZATION

STUDENT:	SCHOOL:	GRADE:	DOB:
ADDRESS:		STATE:	ZIP:
MEDICAL HISTORY:			

TO BE FILLED OUT OR REVIEWED BY THE PRESCRIBING PRACTITIONER:

☐ G-Tube feeding ☐ Jejunostomy feeding ☐ Other_____

☐ Continuous ☐ Intermittent ☐ Bolus ☐ Pump

Feeding fluid type_____ Rate_____Volume_____ Time(s)_____

Flush with _____ml water ☐ before and ☐ after feedings

☐ Hydrate with _____ml water or_____ Time(s)_____

Medical Procedure(s):

1. **Nurse may replace g-tube if needed.**

PRESCRIBING PRACTITIONER AUTHORIZATION: *I have determined that the above described medical procedure is medically necessary during school hours to maintain this child's physical health.*

Practitioner Signature:_____ Date:_____
Office Phone:_____ Fax Number:_____

PARENT/GUARDIAN AUTHORIZATION*: The school authorized personnel has my permission to administer the above Medical Procedure. I will also adhere to the following conditions of this agreement:*

1. I will bring this form into the office completed and signed by my health practitioner before expecting this medical procedure to be completed at school.
2. I understand that school personnel may not perform the medical procedure until training by the school nurse is completed.
3. I will maintain the supplies needed for this procedure throughout the year
4. I will renew this authorization every time there is a change of any kind regarding the medical procedure.

Parent/Guardian Signature:_____ Date: _____

Home Phone: _____ Emergency Phone:_____