FRISCO ISD
School Health Services

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. This procedure may be performed by: *(select all that apply)*
   Teacher ______ ***Teacher's Aide*** ______ ***School Nurse***______ ***Principal Designee***_____ ***Other***_____

4. Student should be fed with head/upper body elevated at a _______degree angle and should remain upright for _______ minutes after feeding.

5. 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:***

6. Student has had a **Nissan** Fundoplication? ________**Yes** ________**No**

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

   If yes, please specify consistencies, amounts, and feeding precautions. ___________________________________
   ____

8. 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

9. FISD staff has permission to contact physician regarding feeding orders.________ (parent initials)

_______________________________ _______________________________ ____________
Physician Signature *Physician Name (PRINT)* *Date*

_______________________________ ____
Office Telephone Number *Office Address*

_______________________________ ____________
Parent Signature *Date*