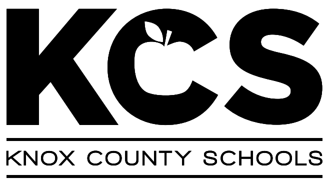

Health Services
GASTROSTOMY/JEJUNOSTOMY FEEDING MEDICAL AUTHORIZATION AND TREATMENT PLAN

Student Name__________________________ Date of Birth______________________________

Diagnosis:____________________________ Type of button/tube: ________________________

Procedure for Feeding: (Parent/Guardian to provide all supplies for procedures)

1. Type of formula
   ☐Pre-Packaged Formula (ex. Pediasure, Jevity) ______________________________

   ☐Homemade Formula (Parent prepares at home based on the healthcare providers order)
   If homemade formula, list the ingredients and corresponding amount/volume, proportions that should be included:
   ____
   ____
   ____
   ____

2. ☐Amount of Formula to be given at each feeding______________________________

3. ☐Times to administer feedings at school______________________________

4. ☐Administer by gravity drip or bolus feed over a period of____________minutes

   ☐Administer by infusion pump at a rate of ____________cc's per minute

5. After each feeding flush with__________cc's of water

6. If prescribed, procedure for checking residuals______________________

Special Considerations:
*School nurses do not replace MIC TUBES/Buttons.

1. Routine site care______________________________________
2. Procedure for a clogged tube______________________________
3. Procedure for a dislodged tube______________________________
4. Insert 8FR Foley Cath (bulb deflated) ☐ Yes ☐No

Additional Requirements:
____
____
____

***This form is good for one school year only.**

______________________ ______________________ ______________________
Health Care Provider Signature | Phone | Fax Number

____
Heath Care Provider Address | City | State | Zip Code

I understand additional prescriber authorization forms will be necessary for procedure changes. I also authorize the School Nurse to talk with the licensed health care provider should a question arise.

______________________ ______________________ ______________________
Parent Signature | Date | Phone Number

AD-H-358 (1.22)