Primary Care Provider Authorization: G-Tube Feeding

Student: ______________________ Date of Birth: ______________________

School: ______________________ School Year: ______________________

Type of G-tube	**Pump to be used:**
☐ Button	☐ Yes
☐ Catheter	☐ No
☐ Other (Specify):	☐ Flow rate _______cc/hour

Name of formula: ____

Type of Pump: ____

Gravity: ☐ Yes ☐ No

Volume to be given: _________cc over _______ minutes

Volume of water to follow feeding: _______ cc

Feeding time(s): _______ _______ _______ _______

Positions: During feeding: ______________________________
After feeding: ______________________________

Note to Health Care Provider/Parent/Guardian:

- The parent/guardian will be notified if a tube becomes **clogged or dislodged.**
- School personnel cannot forcefully flush or replace a tube into the stomach.
- Feeding formula must be sent to school in the **original unopened container**.

Additional health care provider's comments: ____
____

______________________________ ______________________________
Printed Name of MD, ARNP, or PA Address

______________________________ ______________ ______________
Signature MD, ARNP or PA Telephone No. Date

*Note to parent/guardian: Signing this form shall release the Jefferson County Public School District and staff from liability of any nature that might result from this plan of action. I hereby give permission for the above information to be verified with the above health care provider.

______________________________ ______________ ______________
Signature of Parent/Guardian Telephone No. Date

______________________________ ______________ ______________
Emergency Contact Relationship Telephone No.