The District School Board of Collier County
Tube Feeding Treatment Authorization Form

Student's Name	Sex	Date of Birth	Student #

School	Fax Number

This form provides professional and parental authorization for medical treatment to be provided during school hours. Both the prescribing physician or health care provider and the parent/legal guardian are required to complete the respective sections of this document entirely before the services can be provided.

Note: Physician's orders are required for all medical procedures administered at school. Please have your child's physician complete this portion of the form and return it to the school or have them fax it to the school nurse.

Physician's Order

The following section is to be completed by the prescribing physician or health care provider:
The student named in this document is under my medical supervision for the diagnosis described below. I have prescribed the following treatment that is necessary to be given during school hours for the child's health or safety. I am also aware that the prescribed treatment may be administered by trained non-medical personnel.

Diagnosis for which tube feeding will be required in school:			**ICD 10 Code**
Type of gastrostomy appliance placed:	□ Peg, □ Button, □ G-Tube, □ Other, describe		
Type of tube feeding formula:		Amount:	
Type of tube feeding flush:		Amount:	
Time and frequency of feedings:			
Is it necessary to measure residual stomach contents? □ Yes, □ No If yes, will the residual content alter feeding volume? □ Yes, □ No If yes, please indicate the residual amount that would prohibit feeding at the prescribed time ____ cc total volume.			
Tube feeding method: □ Bolus by gravity, □ Bag, □ Syringe, □ if pump malfunctions may do bolus feeding □ Mechanical pump – Type of pump _____ Rate of flow _____			
Is student allowed oral feedings? □ Yes, □ No, If yes, Type: _____ Frequency:_____			

Physician's Name (Print): _____ Phone Number: _____

Physician's Signature: _____ Date: _____ Fax Number: _____

□ Verbal Order Obtained Time: _____

Nurse's Signature: _____ Date: _____

Parent/Legal Guardian Permission

The following section is to be completed by the parent/legal guardian:
I hereby grant permission to the principal or his/her designee of _____ school to assist in the administration of the above prescribed treatment to my child while in school and away from school while participating in official school activities (F.S. 1006.062). **It is my responsibility to notify the school if and when these orders change.** I understand that the law provides there shall be no liability for civil damages as a result of the administration of such treatment where the person administering such treatment acts as an ordinarily prudent person would under the same circumstances. I have also been advised that if my child's G-Tube is dislodged or removed, it will not be replaced by school personnel. When it becomes dislodged I will be immediately contacted by school personnel to seek medical attention and direction for my child.

Special Instructions:					
My child has:	□ No allergies, □ The following allergies				
Parent/Guardian Name:				Relationship:	
Home phone:		Business phone:		Emergency phone number:	

1. I give permission for my child's doctor to be contacted for information regarding the administration of the treatment listed on this form.
2. I agree that all treatment supplies will be discarded the last day that school is open if not picked up.

Parent/Guardian Signature:		Date:	

Rev 4/15

The District School Board of Collier County
Tube Feeding Treatment Authorization Form
For Administration During School Hours

Dear Parent/Legal Guardian:

If your child needs to have treatment(s) administered during the school day, State Regulations and School Board Guidelines require that you and your doctor provide written permission for administration of the prescribed treatment(s). Treatments that are to be given only one time per day or that may be administered before or after school should be administered at home.

(Treatments refers to only those products which have been approved by the "Food and Drug Administration" (FDA) for use as a drug or food substitute.

- A parent/legal guardian or an authorized adult must hand carry treatment solutions and supplies to the Health Room. Do not send supplies to school with your child.

- Prescribed treatments must arrive in a container with the original, unaltered prescription label attached. The label must display all legal information required for a pharmacist to dispense a prescription medication such as valid issue and expiration dates, the patient's name, the Treatment name and dosage instructions, and the doctor's name.

- The treatment authorization on the reverse side of this document must be completed entirely and accompany any solutions or supplies to be given to your child in school. The form must be signed by a parent/legal guardian and the prescribing doctor as indicated. Staff will not be able to administer treatments to your child without this written consent.

Thank you for assisting us to provide safe treatment administration for your child during the school day.

Please see reverse side of this document for Treatment Authorization

Student Medical History

Student Name _____ **Student #** _____

DOB _____ **School** _____ **Grade** _____ **Teacher** _____

Parent/Guardian Name _____ **Bus Rider**: Yes__ No__

Phone (H) _____ (W) _____ (C) _____

PRIMARY MEDICAL DIAGNOSIS:

_____

_____

Year Diagnosed _____

SIGNS AND SYMPTOMS THAT MAY PRESENT AT SCHOOL:

_____

_____

ACTIONS TO BE TAKEN AT SCHOOL:

_____

_____

CURRENT MEDICATIONS: (Attach additional pages as needed)

Drug Name	*Dose*	*Purpose*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diastat _____ Epi-pen _____ Other _____

SURGERIES: (Attach additional pages as needed)

Type _____ *Year* _____
Type _____ *Year* _____
Type _____ *Year* _____

HOSPITALIZATIONS: (Attach additional pages as needed)

Reason _____ *Year* _____
Reason _____ *Year* _____
Reason _____ *Year* _____
Reason _____ *Year* _____

ALLERGIES: (Attach additional pages as needed)

Allergic to	*Reaction*	*Action*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Student Name _____ **Student #** _____

PRIMARY PHYSICIAN:
Name: _____
Address: _____
Phone: _____ Fax: _____

MEDICAL SPECIALISTS:
Name: _____ Phone: _____
Address: _____ FAX: _____

Name: _____ Phone: _____
Address: _____ FAX: _____

Name: _____ Phone: _____
Address: _____ FAX: _____

General Health History **Enter dates into any boxes that apply to your child's health history**

Past	Present	
		Accidental injuries/severe head injury
		ADHD
		Asthma/respiratory condition
		Bee sting/insect allergy
		Bladder disorder
		Cancer/Tumor
		Diabetes
		Diarrhea/constipation/toileting issues
		Disorder of the blood
		Ear problems
		Emotional concern
		Eye problems/Glasses
		Food, drug, or environmental allergies

Past	Present	
		Frequent colds/flu
		Hearing problems/Hearing devices
		Heart problem
		Kidney disease
		Muscular disorder
		Seizures/convulsions
		Serious infections/high fevers
		Severe burns
		Severe headaches
		Skin problems
		Swallowing or choking difficulties
		Other:
		Other:

Does your child walk independently? Yes _____ No _____
Is any adaptive equipment required? Yes _____ No _____
If yes, please specify:
_____
_____
_____

Does your child have any dietary concerns or feeding / eating problems? Yes _____ No _____
If yes, specify:
_____
_____
_____
_____

Does you child have any activity restrictions? Yes _____ No _____ (If yes, please specify)

_____
_____
_____

Toileting? Specify any special needs

_____
_____
_____

Will your child require any medical treatments while at school? (Ex: nebulizer, injections, tube feeding)

_____
_____
_____

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my child's health. I understand that this information is confidential and will be shared on a need to know basis. This information is protected by law.

I give permission for my child's health care provider to be contacted for information regarding my child's medical condition. I have reviewed and agree with the information as listed on this Individualized Healthcare Plan.

_____ _____
Signature of Parent **Date**

_____ _____
Reviewed by (Nurse Signature) **Date**