

MEDICAL PROCEDURE AUTHORIZATION FORM

Date: _____ **Program:** _____ **School Year** _____

Student's Name _____

Licensed Prescriber's Orders:

Procedures to be given during school hours with specific instructions:

1. **Gastrostomy tube feeding orders:**

Type of Formula: _____ **ml's or cans given:** _____

Time to be given: _____ **How long feeding should run:** _____

Route via G-tube: gravity _____ syringe _____ pump _____

Water flush: _____ **ml's** _____ **PRN G-tube Replacement if G-tube comes out: Yes or NO**

2. _____

3. _____

4. _____

Licensed Prescriber's Signature: _____

Address: _____

Phone Number: _____ Fax Number: _____

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I, _____, give permission for my child to receive the above medical procedure(s) as directed by the licensed prescriber. I will notify the school in writing if the procedure is discontinued, and I will obtain a written order from the licensed prescriber if the procedure is changed. I will bring the material/supplies needed for the medical procedure to the school nurse or notify the school nurse if extenuating circumstances exist regarding transportation of the supplies to the educational setting.

Date _____

Parent/Guardian Signature _____

Address _____

City, State, Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____