



# SPECIFIC HEALTH CARE PROCEDURES AUTHORIZATION FOR G-TUBE FEEDING

FAIRFAX COUNTY HEALTH DEPARTMENT

## PART 1: PARENT TO COMPLETE

Student Name: Last	First	M.I.	(DOB)	Grade	Year
Home Phone	Father Work Phone	Mother Work Phone			

## PART 2: Health Care Provider TO COMPLETE

### Physical condition for which the specific procedure is to be performed

### Name of specific procedure

- G-Tube feeding  
 Venting

### Check one:

- I reviewed and approved the orders for G-tube feeding as written on the second page.  
 I authorized parents/guardians to adjust G-tube feeding as needed as written on the second page.

### Precautions, possible adverse reactions

Precautions: exposure to bodily fluids, and \_\_\_\_\_

Possible adverse reactions: vomiting, feeding intolerance, choking, dislodgement of G-tube, and \_\_\_\_\_

### Time to be given at school and/or indications for the procedure. Please check box for duration.

Per health care provider and/or parent instruction on the second page

- Current school year \_\_\_\_\_ OR  Effective date \_\_\_\_\_ to \_\_\_\_\_

### If procedure requires medication, complete Medication Authorization form

Student is to self-administer the procedure:

- NO  
 YES I believe that this student has received adequate instruction on how and when to perform this procedure, and that they can do the procedure independently.

### Health Care Provider Information

\_\_\_\_\_  
(Print Health Care Provider's Name)

\_\_\_\_\_  
(Print Address)

\_\_\_\_\_  
(Telephone)

\_\_\_\_\_  
(Health Care Provider's Signature)

\_\_\_\_\_  
(Date)

## PART 3: DISCLOSURE AND PERMISSION. Parent/Guardian to Complete and Sign.

- I hereby acknowledge that this medical information will be shared only with appropriate school staff members.
- I hereby request that identified members of the school staff of \_\_\_\_\_ school be caretakers of medication, supplies, and equipment and administrators of specific procedure(s) for the student named above, as ordered by our health care provider.
- I hereby authorize Fairfax County Public Schools (FCPS) and Fairfax County Health Department (FCHD) personnel to facilitate the procedure or medication directed by this authorization. I agree to release, indemnify, and hold harmless FCPS and FCHD and any of their officers, staff members, or agents from lawsuit, claim, expense, demand, or action, etc., against them for assisting this student with the use of medication or procedure, provided FCPS and FCHD staff members comply with the health care provider or parent or guardian orders set forth in accordance with provisions of the current version of Regulation 2104. No School Board employee, school public health nurse, or school health aide shall facilitate the use of medication or procedure as an exception under School Board policy, unless all the required clearances have been personally reviewed by the principal or the designee.
- I give permission to contact the above named health care provider to clarify information provided on the authorization should the need arise.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

Information from the Fairfax County Public Schools student scholastic record is released on the condition that the recipient agrees not to permit any other party to have access to such information without the written consent of the parent or of the eligible student.

## HEALTH CARE PROVIDER ORDERS FOR G-TUBE FEEDING

Student Name: _____	Date of Birth: _____
<b>Venting:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ● Time and/or symptoms for venting: _____	
<b>Feeding by:</b> <input type="checkbox"/> Gravity <input type="checkbox"/> Pump	
<b>Type of G-Tube Pump:</b> <input type="checkbox"/> Kangaroo <input type="checkbox"/> Infinity <input type="checkbox"/> Other: _____	
<b>Brand of Formula:</b> _____ <input type="checkbox"/> Parent/guardian are authorized to change the brand of formula <input type="checkbox"/> Parent/guardian are authorized to send home-made pureed food for the student	
<b>Time(s) to Feed:</b> _____ <input type="checkbox"/> Parent/guardian are authorized to adjust feeding time +/- _____ minutes	
<b>Amount to Feed at Each Feeding (in ml or oz):</b> _____ <input type="checkbox"/> Parent/guardian are authorized to adjust feeding amount +/- _____ <input type="checkbox"/> ml <input type="checkbox"/> oz	
<b>Rate on Pump:</b> _____ <input type="checkbox"/> Parent/guardian are authorized to adjust rate +/- _____ ml/hour	
<b>Amount of water flush before feeding:</b> _____ <input type="checkbox"/> ml <input type="checkbox"/> oz by <input type="checkbox"/> Gravity <input type="checkbox"/> Pump	
<b>Amount of water flush after feeding:</b> _____ <input type="checkbox"/> ml <input type="checkbox"/> oz by <input type="checkbox"/> Gravity <input type="checkbox"/> Pump	
G-Tube extension tubing stays connected to the student after the feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No	
G-Tube extension tubing goes home with the student daily: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other instructions: _____	

\_\_\_\_\_  
(Health Care Provider's Signature)

\_\_\_\_\_  
(Date)

<b>Orders Adjusted by Parents/Guardians:</b>		
<input type="checkbox"/> See written instructions from parents/guardians as attached:		
_____ School Public Health Nurse Name (Print)	_____ School Public Health Nurse Name (Signature)	_____ (Date)
<input type="checkbox"/> See written instructions from parents/guardians as attached:		
_____ School Public Health Nurse Name (Print)	_____ School Public Health Nurse Name (Signature)	_____ (Date)
<input type="checkbox"/> See written instructions from parents/guardians as attached:		
_____ School Public Health Nurse Name (Print)	_____ School Public Health Nurse Name (Signature)	_____ (Date)
<input type="checkbox"/> See written instructions from parents/guardians as attached:		
_____ School Public Health Nurse Name (Print)	_____ School Public Health Nurse Name (Signature)	_____ (Date)
<input type="checkbox"/> For additional orders received, check box, attach orders, and note new effective date for each additional order:		