AUSTIN Independent School District | Health Services and Nursing

Authorization for Feedings

The School Nurse will review the order & ensure that it is completed & dated. Feedings will be provided when this form is completed in its entirety by both physician(s) & parent/guardian(s). Feedings may be delegated to trained Austin ISD staff.

Student Name _____ DOB _____ School ID _____

Food allergies: _____

Drug allergies: _____

Diagnosis: _____

Enteral feeding: ☐ Enteral feeding only, nothing by mouth ☐ Enteral and oral feeding

Type of gastrostomy: ☐ G-Button ☐ G-tube ☐ PEG ☐ Other (describe) _____

Tube feeding method: ☐ Mechanical pump ☐ Syringe ☐ Gravity

Tube feeding formula name:		Volume of formula per feed:	mL	Rate of feed:	mL/hr
Tube feeding formula preparation	☐ Ready to feed	☐ Per manufacturer	☐ Homemade blended		
Water flush volume after feeding:	mL	Times/frequency of feeding:			
Water bolus volume:	mL	Rate of bolus:	mL/hr	Times/frequency of water bolus:	

*AISD RN/Staff do not reinsert dislodged gastrostomy tubes. Cover stoma with gauze an tape. Parent will be notified immediately, EMS will be activated if reinsertion not achieved within 4 hours.

Hold enteral feeding: ☐ Vomiting ☐ Respiratory distress ☐ Gastric residual volume over _____ mL

Resume feedings ☐ Gastric residual volume under _____ mL Other (specify) _____

Diet / Food Preparation:

Diet type: ☐ Regular ☐ Modified- please specify: _____

Food Consistency: ☐ Pureed ☐ Ground ☐ Chopped ☐ Mashed ☐ Bite Size

Liquid Consistency: ☐ No liquids ☐ Thin liquids ☐ Thickened liquids- please specify:

☐ Nectar ☐ Honey ☐ Pudding

Feeding Plan Techniques / Precautions:

Positioning: _____ Equipment: _____

Amount of food per bite: _____ Food Placement: _____

☐ Maintain upright position ___ minutes after meal(s) ☐ Offer liquid after ___ bites

Additional Precautions / Comments: _____

_____

_____ _____

Medical Provider Signature Printed name/Stamp

_____ _____ _____

Phone Fax Date

_____ _____ _____

Parent/Guardian Signature Printed name Date