THE SCHOOL BOARD OF ST. LUCIE COUNTY
9461 Brandywine Lane, Port St. Lucie, FL 34986
(772) 429-4570

AUTHORIZATION FOR SCHOOL GASTROSTOMY FEEDINGS

STUDENT: _____DOB: _____ ICD-9 Diagnosis Code _____

SCHOOL: _____GRADE: _____

Part I: (to be completed by physician)

Treatment Procedure (check one):

___ I have reviewed and approved the attached standardized treatment/procedure as written.
___ I have reviewed and approved the attached standardized treatment/procedure with my modifications.
___ I have attached my recommendations for treatment/procedure for this student.

Name of nutrient: _____amount to be given each feeding: _____

Amount of water to follow feeding: _____time(s) to be given during school hours:_____

Precautions or possible reactions and recommended interventions (please include emergency signs/symptoms specific to child): _____

_____

Treatment/Procedure to be continued as above until (date): _____

_____ _____
Physician's Signature Physician's Name – Printed

_____ _____
Address Telephone & Beeper #

Part II (to be completed by parent**):**

I hereby request and give permission for my child to be given the above prescribed treatment/procedure while in school. I will notify the school immediately if the health status of my child changes, we change physicians, or if there is a change in treatment/procedure. I understand that if there is special equipment or supplies needed to perform this treatment/procedure, it will be maintained by me, delivered to the school in good working condition, and school personnel will assume no responsibility for the maintenance and/or delivery of special equipment/supplies.

_____ _____
(Legal) Parent/Guardian Signature **Date**

Part III (for school use only):

_____ _____
Principal's Signature Date

_____ _____
School Paraprofessional Signature Date

_____ _____
School Health Coordinator Signature Date