ANNE ARUNDEL COUNTYSCHOOL HEALTH SERVICES PROGRAM

PARENT'S REQUEST FOR ENTERAL FEEDING ORDER AT SCHOOL

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student:_____ D.O.B:____/____/____
(LAST) (FIRST) (MI)

Name of School:_____ Grade:_____ School Year: _____

The undersigned parent(s) (or guardian) of _____ hereby request(s) personnel employed by either the Anne Arundel County Public Schools or the Anne Arundel County Health Department to see that said child receives Enteral Feedings/Treatment **AS PRESCRIBED BELOW BY THE CHILD'S PHYSICIAN.** It is required by the Anne Arundel County Public Schools and Anne Arundel County Health Department as a condition to its agreement to administer any treatment that the parent must supply the school with supplies for all procedures and be present for the first time a treatment is performed. It is understood that the treatment is administered solely at the request of and accommodation to the undersigned parent(s) or guardian. In consideration of the acceptance of the request to perform this service by any personnel employed by either Anne Arundel County Public Schools or Anne Arundel County Health Department the undersigned parent(s) or guardian hereby agree(s) to release the said institutions and their personnel from any legal claim(s) which they now have or may hereafter have arising out of the performance of the treatment to the student.

I understand that this procedure will be performed using standard nursing procedures. If the procedure is uncomplicated and my child's condition is stable; the school nurse may, at her discretion, teach unlicensed personnel this procedure. School or health personnel may assist toward independence in care if indicated.

Signature of Parent/Guardian:_____ Date: _____

Relationship to student _____ Phone: _____

PHYSICIAN'S SIGNED ORDER FOR ENTERAL FEEDING AT SCHOOL

Diagnosis: _____

Allergies: ☐ None Known _____

I request the following Treatment/Procedure be administered during school hours:

Type of tube: GT ☐ JT ☐ GT/JT☐ NGT☐ FR Size/Length: _____ Balloon Volume: _____ Water Air (please circle)

Formula: _____

Volume: _____ ☐ Via Pump ☐ Bolus
Rate: _____ ☐ Gravity by syringe
Time(s): _____ ☐ Push via syringe
☐ Gravity by bag

Water Flush/Bolus:
Volume: _____ ☐ Via Pump ☐ Bolus
Rate: _____ ☐ Gravity by syringe
Time(s): _____ ☐ Push via syringe
☐ Gravity by bag

Venting: ☐ As needed for abdominal distention, discomfort
☐ Prior to feeding ☐ Other**:** _____

If tube becomes dislodged: ☐ Replace with tube size noted above ☐ Call Parent ☐ Call 911

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed:

_____

Services should begin (Date)_____ and terminate (Date) August 20, 2023.

Physician's Signature: _____ Date: _____
Original signature/NO stamps

Physician's Name: (Printed)_____ Phone: _____

Physician's Address: _____ City:_____ Zip Code:_____

☐ Order and MAR Reviewed _____R.N. Date: _____