Fairview Park City School District

21620 Mastick Rd., Fairview Park, OH 44126 P: (440) 331-5500 • F: (440) 356-3545
Keith Ahearn, Superintendent • Rob Showalter, Treasurer
MS/HS Clinic Fax: (440) 356-3529 • **Gilles-Sweet Clinic Fax:** (440) 356-3701 • **EEC Clinic Fax:** (440) 356-3544

Gastrostomy Nutrition Administration Form

A completed form must be provided to the clinic nurse before the student may be administered gastrostomy tube feedings.

Student name	School
Student address	Grade

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize the clinic nurse or person(s) designated to administer gastrostomy tube feedings to my child, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I absolve the Board of Education of the Fairview Park City School District, and all of its officers, agents, and employees of any and all liability, which may arise in any way from the administration of gastrostomy tube feedings to my child.

Parent/Guardian name (print)	Parent/Guardian emergency telephone number
Parent/Guardian signature	Date

This section must be completed and signed by the licensed prescriber: must be the signature of a physician or nurse practitioner.

As the prescriber I agree to provide in writing a revised statement if any of the following information changes.

Type/size of feeding device
Name and amount of nutrition
Time to be administered/duration of administration
Flush instructions
Venting instructions

Procedure if gastrostomy tube is dislodged	
Date administration begins	Date administration ends (if known)

Prescriber name (print)	Prescriber emergency telephone number
Prescriber signature	Date