NEW JERSEY INSTITUTE FOR DISABILITIES
LAKEVIEW SCHOOL
10 OAK DR. EDISON, N.J. 08837
732-549-5580 x2600
Fax: 732-590-2426

SY 2025-2026

AUTHORIZATION TO *ADMINISTER* ***TUBE FEEDING***

Dear Parent/Guardian and Physician:
In order to meet the state requirements, the following form must be completed in order for your child to receive a tube feeding while in school. **The parent is responsible for sending in all necessary supplies to administer the prescribed tube feeding.**

Any questions please call 732-549-5580 ext. 2600

If tube feeding must be administered during the school day, please complete this form. Your physician must complete the lower portion of this form.

I hereby give permission for the School Nurse of Lakeview School to tube feed my child.

With my doctor's approval, my child's feeding time may be adjusted/flexed to accommodate class trips, during the school year. YES ______ NO ______

Type of treatment:________________________________
Time: ________________________________
Other: ________________________________

Supplies provided by parent: ____

****Known Allergies:** ____

Date: _________________ ______________________________________
Signature of Parent/Guardian

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TO BE FILLED IN BY PHYSICIAN **Orders valid July 1, 2025, thru June 30, 2026**

Name of Student:______________________________________ **shall be given**

____
Name of formula for tube feeding

____________________ ____________ _________________ _____________
Quantity of formula **Time(s)** **Duration of feeding** **Flush/Amount**

____
Reason for feeding

____
Physician Special Instructions

Patient's feeding time may be adjusted/flexed to accommodate class trips, during the school year.
YES ______NO ______

_________________________________ _____________ _________________________________
Signature of Physician (no stamp) **Date** **Address**

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AUTORIZACION PARA *ADMINISTRAR* *ALIMENTO POR TUBO*

Estimado padre/tutela y doctor:
Para cumplir con los requisitos del estado, la siguiente forma necesita ser completado para que su hijo/a pueda recibir tratamiento médico cuando está en la escuela. **Los padres son responsables de enviar todas los equipos necesarios para administrar el tratamiento médico prescrito.**

Si tiene preguntas favor de llamar al 732-549-5580 ext. 2600

Si el tratamiento se requiere que sea administrado durante la hora de escuela, favor de completar esta forma. Su doctor necesita completar la porción de debajo de la forma.

Yo doy permiso a la enfermería escolar de la escuela de Lakeview de administrarle lo siguiente para mi hijo/a.

Con la aprobación del doctor, el horario del alimento de mi hijo/a puede ser ajustado/flexible para acomodar los paseos del salón de clase durante este año escolar. Si ______ NO ______

Tipo de tratamiento: ________________________________
Horario: ________________________________
Otro: ________________________________

equipo proveído por los padres: ____

****alergias:** ____

Fecha: __________________ ________________________________
Firma de padre/Tutela

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TO BE FILLED IN BY PHYSICIAN (completado por su doctor) **Orders valid July 1, 2024 thru June 30, 2025**

Name of Student: ________________________________ **shall be given**

____
Name of formula for tube feeding

__________________ __________________ __________________ __________________
Quantity of formula **Time(s)** **Duration of feeding** **Flush/Amount**

____
Reason for feeding

____
Physician Special Instructions

Patient's feeding time may be adjusted/flexed to accommodate class trips, during the school year.
YES ______NO ______

________________________ ____________ ________________________
Signature of Physician (no stamp) **Date** **Address**