G-Tube Feeding Order Form for School Feedings

Student: _____ **ID #:** _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **School Year:** _____

TYPE OF FEEDING DEVICE

❑ Gastrostomy tube
Type: _____Size:___ Adjusted tube length_____

❑ Gastrostomy button
• MicKey • Bard • Other: _____

❑ Jejunostomy tube or ❑ Gastro-jejunostomy tube
Type: _____Size:_____ Fr_____ cm

FEEDING METHOD

❑ Bolus ❑ Gravity drip ❑ Pump

Type of pump: _____

Flow Rate: _____cc/hr

Flush tube with _____cc water after feeding

FORMULA FEEDING

Type: _____

Amount: _____

Time(s): _____

WATER

Amount before feeding: _____

Amount after feeding: _____

Other: _____

RESIDUAL

❑ Residual check not necessary

❑ Check residual:
Feed if residual <_____ Hold if residual >_____

❑ Further instructions:_____

Note to Healthcare Provider & Parent/Guardian:
The parent/guardian will be notified if the tube becomes clogged or dislodged. School personnel cannot forcefully flush or replace a tube into the stomach.

ORAL FEEDINGS

❑ NPO (Nothing by mouth)

❑ Other*: _____

_____

_____

**All oral feeding diets must be coordinated through nutrition services (706-265-3246) or the school's Speech & Language Pathologist*

Additional healthcare provider comments: _____

_____

Authorized Healthcare Provider's Authorization for Management of Gastrostomy Feeding in School

My signature below provides authorization for the above-written orders. I accept responsibility for monitoring that adequate, safe arrangements are made for the performance of the above service. I may be called by school personnel regarding the above recommendations. I will be monitoring the ongoing health status of this patient. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of 1 year. If changes are indicated, I will provide new written authorization.

Provider Printed Name: _____ **Signature:** _____

Date: _____ **Duration of order:** _____ **Phone:** _____ **Fax:** _____

Parent/Guardian Consent

I request that the above treatment be performed for my child by Dawson County School District personnel. I understand that this treatment must be performed during school hours to enable my child to attend school. I also understand that this service may be provided by non-medical personnel after appropriate training. I agree to supply all necessary equipment ready for use and to notify the school nurse of any changes in my child's health status.

Parent/Guardian Name: _____ **Signature:** _____ **Date:** _____