RICHMOND CITY PUBLIC SCHOOLS HEALTH SERVICES
PHYSICIAN'S ORDER FOR GASTROSTOMY TUBE FEEDINGS AT SCHOOL

STUDENT'S NAME: _____ DOB: _____
School: _____ School Year: _____
ALLERGIES: _____
DIAGNOSIS (REASON FOR TUBE FEEDING)**: _____**

TYPE OF GASTROSTOMY APPLIANCE PLACED:
☐ PEG ☐ BUTTON ☐ G-TUBE ☐ OTHER_____ SIZE: _____
DATE AND SITE OF TUBE PLACEMENT: _____
THE TREATMENTS NEEDED DURING SCHOOL HOURS ARE:
☐ **FEEDING BY GRAVITY** ☐ **FEEDING BY PUMP** **TYPE OF PUMP: _____**

☐ **G-TUBE MEDICATIONS to be administered at school:**

MEDICATION NAME	DOSE	FREQUENCY	TIME

PROCEDURE FOR FEEDING ADMINISTRATION:

1. **POSITION STUDENT:**
   - ☐ Sitting upright or semi- reclining with head at_____degree angle **-OR-**
   - ☐ Lying on right side with head elevated at _____degree angle **-AND-**
   - ☐ Remain elevated for_____minutes after feeding is administered.
2. **ASPIRATE:**
   - ☐ **I DO** order to check for aspirate: If aspirate is greater than _____cc:
   - ☐ FEED ☐ Delay feeding for _____minutes and repeat aspiration ☐ DO NOT FEED
   - ☐ If aspirate is greater than _____cc, contact parent**.**
   - ☐ **I DO NOT** order to check for aspirate.
3. **FLUSHING:**
   - ☐ **I DO** order G-Tube to be flushed: ☐ **BEFORE** feeding or medication with ____cc of water.
     ☐ **AFTER** feeding or medication with _____cc of water.
   - ☐ **I DO NOT** order G-Tube to be flushed.
4. **PLEASE SPECIFY DIET/FLUID:** TYPE/NAME OF FORMULA:_____
   AMOUNT_____ RATE (if pump):_____
   Frequency of feedings during school day: _____
   Please give_____cc of FREE WATER at (time/frequency) _____
5. **IF G-TUBE DISLODGES AT SCHOOL:** ☐ Cover site with clean gauze and promptly notify parent.
   ☐ Replace with replacement device provided by family.

Please Note: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication and perform procedures.

Physician Signature: _____ Date: _____

Physician Name Printed: _____ Phone #:_____

Parent's (Guardian's) Signature: _____ Date: _____