Physician Order for G-Tube Feeding Procedure

Sunnyside School District

Student: _____Date:_____

DOB:_____School: _____Teacher/Grade: _____

Licensed Health Care Provider to complete section below:

THE TREATMENTS NEEDED DURING SCHOOL HOURS ARE: (please indicate)

▢ Feeding by gravity ▢ Feeding by pump ▢ Feeding by push syringe

▢ G-Tube medications - please list medication, dosage, frequency, and administration time:

_____

PROCEDURE FOR FEEDING ADMINISTRATION:

1. **POSITION STUDENT**
   - ▢ Sitting upright ▢ Semi-reclining at _____ degree angle
   - ▢ Remain elevated for _____ minutes after feeding is administered
   - ▢ Other: _____
2. **RESIDUAL** - Check One:
   - ▢ I DO NOT order to check for residual.
   - ▢ I DO order to check for residual. If residual is greater than _____ml, contact parent.
3. **FLUSHING** - Check one:
   - ▢ I DO NOT order for the G-tube to be flushed.
   - ▢ I DO order for the G-tube to be flushed: ▢ Before feeding or medication with _____ml of water
     ▢ After feeding or medication with _____ml of water
4. **PLEASE SPECIFY DIET/FLUID:**
   Type of Feeding: _____Amount: _____
   Frequency of feeding during the school day: _____
   ▢ It is OK for parent/guardian to direct changes in frequency / amount / times of feedings.
5. **COMMENTS:**
   _____

   _____

*Physician's orders need to be renewed every school year OR when changes are made to the care plan.
This order is good for school year _____.

_____ _____/_____ _____

(Physician's Signature) (Telephone / Fax Numbers) (Date)

Parent/Guardian Statement

▢ I, the undersigned parent/guardian of _____, hereby request the School Nurse or trained staff member to administer the above procedure(s) and medication(s) according to the Physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary. **I agree to notify the School Nurse immediately if there is any change in the student's health status or Physician's orders.**

▢ Yo, el padre/tutor de _____ , solicitó a la enfermera escolar o a un miembro del personal capacitado que administre los procedimientos y medicamentos anteriores de acuerdo con las instrucciones del médico. Acepto proporcionar todo el equipo, suministros, medicamentos u otros artículos necesarios para la administración del servicio/procedimiento y proporcionar reemplazo y mantenimiento según sea necesario. **Acepto notificar a la enfermera escolar inmediatamente si hay algún cambio en el estado de salud del estudiante o en las órdenes del médico.**

_____ _____ _____

Signature / Firma **Phone number/Numero de telefono** **Date/Fecha**