Inspiring Excellence

LAKE STEVENS
School District

School:
Work Cell:
Office Phone:
Office Fax:

# TUBE FEEDING:
# ANNUAL PHYSICIAN ORDER & INDIVIDUAL HEALTH CARE PLAN

*To be completed by the student's Physician and returned to School. Good for _____school year only.*

STUDENT'S NAME: _____ DOB: _____

SCHOOL: _____ GRADE: _____

Type of feeding tube:_____ Length: _____ Diameter: _____ Amount of water to inflate balloon:_____mL
Year tube placed: _____ Reason for feeding tube:_____
Feeding tube used for ☐ Feeding ☐ Medication ☐ Both
Can student eat/drink anything by mouth? ☐ No ☐ Yes
Does the student have dysphagia? ☐ No ☐ Yes - If yes, please complete Annual Feeding/ Swallowing Form

Medications
*(if medications to be given at school please fill out medication order form)*

| Name of Medication | Dose | Time Given | Route |
|---|---|---|---|
| | | | |
| | | | |

**All feeding/ positioning/ fluid volumes per parent's direction ☐ Yes ☐ No**

**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** - Check one:
   - ☐ I DO order to check for aspirate
     If aspirate is greater than _____ mL, ☐ Feed ☐ DO NOT feed
     ___ Delay feeding for ( ) minutes, and repeat aspiration.
     ***If aspirate continues to be greater than _____, contact parent.
   - ☐ I DO NOT order to check for aspirate.
3. **FLUSHING** – **Check one:**
   - ☐ I order G-tube to be flushed: ☐ Before feeding or medication with _____mL of free water.
     ☐ After feeding or medications with _____ mL of free water.
   - ☐ Are there Fluid Restrictions? ____ Yes _____ No If yes, how much? _____mL
4. **FEEDING TYPE:** ☐ Feeding by gravity ☐ Feeding by pump ☐ Feeding by bolus
   If feeding by pump: Type of pump: _____ Run at: _____ mL/hr

Continued on next page

5. **PLEASE SPECIFY DIET That will be given during school day:**

TYPE OF FORMULA: _____ Amount: _____

Frequency of feedings during school day: _____

***Please give water push of _____mL ☐ PRN ~or~ ☐ Specified Times: _____

Additional Comments on Feeding: _____

_____

_____

_____

6. **VENTING – Check one:**

☐ I DO order venting, check type of venting

- ☐ Venting via Farrell Bag ☐ Venting with syringe
- ☐ PRN Venting OR ☐ Scheduled Venting - If scheduled, when? _____
- Duration of Venting: _____

☐ I DO NOT order venting

7. Hold feedings if: _____

8. If feeding tube is displaced at school. *Check all applicable boxes.*

☐ Parent and/or legal guardian has been trained to replace feeding tube.

☐ Child must see their doctor or surgeon for reinsertion of the feeding tube.

☐ If available, a licensed, trained health professional may replace feeding tube.

9. COMMENTS: _____

_____

X _____ _____ _____

(Physician's Signature) Date Fax Number

_____ _____

(Physician's Name - Printed) Telephone Number

* ***PLEASE NOTE: Trained non-medical staff to administer G-tube feedings.***

## 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 understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed.
- I understand that I must provide all necessary supplies and equipment to perform this service.
- I understand that I will provide replacement supplies and maintenance as necessary.

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

**Home Phone: _____ Work: _____ Cell: _____**

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***Reviewed by: _____ Date: _____***