Pasco School District No. 1
Nursing Services
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Pasco School District Specialized (Enteral/Tube) Feeding Orders for School

Student Name: _____ ***DOB:***_____ ***School Year:*** _____

School: _____ ***Phone:***_____ ***Fax:*** _____

Type of Tube: ☐G Tube_____ ☐J Tube_____ ☐GJ Tube_____ ☐NG Tube_____
(NON delegable)

Method:

☐Pump:
Type of formula: _____
Amount of formula: _____Rate: _____ ml / hr.

☐Gravity Bolus ☐Syringe Push
Type of formula: _____
Amount of formula: _____Duration: _____

Feeding Time(s): _____ ☐and PRN

Access Tube for: ☐ Feeding ☐Medication Administration ☐Both

Flush after feeding/med admin: ☐No ☐Yes Amount: _____

Vent before feeding: ☐No ☐Yes Minutes: _____

Special positioning during feeding: ☐No ☐Yes: Position/Minutes: _____
Special positioning after feeding: ☐No ☐Yes: Position/Minutes: _____

Hold feeding if: _____

If Tube is displaced at school: (Parents must administer first feeding when a new tube is placed)
☐ Parent and/or legal guardian have been trained to replace the tube.
☐Child must see doctor or surgeon for reinsertion.

Is the student able to eat/drink by mouth?
☐No ☐Yes: Foods/Drinks Allowed: _____
Texture Modification: ☐Soft ☐Puree ☐ Chopped
Modified Liquids: ☐ Regular liquids allowed ☐ Thickened liquids only

Is the student at increased risk for choking?
☐ No ☐ Yes: Approximate date of last swallow study: _____
Other recommendations/precautions:

Health Care Provider Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____