# Owasso Public Schools

**Health Services**
**20____ -20____**

**PHYSICIAN ORDERS FOR G-TUBE FEEDINGS**

**To be completed by the student's Physician, signed by parent, and returned to school, Attn: School Nurse**

**STUDENT'S NAME: _____ DOB: _____**
**GRADE/TEACHER: _____ SCHOOL: _____**
**PHONE NUMBER: _____FAX NUMBER: _____**
**DIAGNOSIS: _____ ALLERGIES: _____**
**TYPE OF FEEDING TUBE: _____ SIZE: _____**
**THE TREATMENTS NEEDED DURING SCHOOL HOURS ARE: (please indicate):**

- ❑ **Feeding by gravity** ❑ **Feeding by pump**
- ❑ **G-tube medications – Please list drug, dosage and frequency:_____**
  **_____**

**PROCEDURE FOR FEEDING ADMINISTRATION:**

1. **<u>POSITION STUDENT</u>**
   - ❑ **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. **<u>ASPIRATE</u> – Check one:**
   - ❑ **I DO order to check for aspirate**
     **If aspirate is greater than _____cc, ❑ 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. **<u>FLUSHING</u> – Check one:**
   - ❑ **I DO order G-tube to be flushed**
     - ❑ **Before feeding or medications with _____cc of free water**
     - ❑ **After feeding or medications with _____cc of free water**
   - ❑ **I DO NOT order G-tube to be flushed**
4. **<u>PLEASE SPECIFY DIET -</u> that will be given during school day:**
   - ❑ **TYPE OF FEEDING/FORMULA: _____ Amount: _____**
     **Frequency of feedings during school day: _____**
   - ❑ **It is ok for parent/guardian to direct changes in frequency/amount/ times of feedings**
   - ❑ **Please give _____of free water at (indicate time)_____ AM _____PM**
   - ❑ **I DO order for student to take food/formula/water by mouth as tolerated (specify):_____**
   - ❑ **I DO NOT order for student to take anything by mouth**
5. **<u>DIRECTIONS FOR DISLODGED G-TUBE</u>:**

_____

_____

_____

**Physician's Signature_____ Date_____**
**Physician's Name (printed)_____ Phone_____**

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***PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer g-tube feedings and medication.**

## 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 status or Physician's orders. Physician's orders need to be renewed every school year OR when changes are made to care plan.**

Parent/Guardian Signature: _____ Date_____/_____/_____
Home Phone: _____ Work: _____ Cell: _____

Reviewed by: _____, RN Date: _____