

LICENSED HEALTH PROVIDER'S FEEDING TUBE PROCEDURE REQUEST AT SCHOOL

STUDENT NAME	DOB	SCHOOL	FAX	SCHOOL YEAR

TO BE COMPLETED BY A LICENSED HEALTH PROVIDER WITH PRESCRIPTIVE AUTHORITY

Type of Feeding Tube	☐ G-Tube ☐ J-Tube ☐ GJ-Tube	Brand/ Profile _____ Inflate _____
Method of Delivery- Feeding	☐ G-Tube ☐ J-Tube	
Method of Delivery- Medications	☐ G-Tube ☐ J-Tube ☐ Other _____	
Formula Name/ Recipe	_____	
	Prepared by family ☐ Yes ☐ No	
Feeding Infusion Rate	_____ ml/hr	
	Parent can adjust rate ☐ Yes ☐ No No slower than _____ ml/hr ; No faster than _____ ml/hr	
Frequency or Duration	☐ Continuous Feed _____ hrs/day ☐ Bolus/Total volume _____ ml	
	Times of feeding _____	
	Parent can adjust timing ☐ Yes ☐ No Parent determined time(s) _____	
Feeding Method	☐ Bolus ☐ Gravity ☐ Pump (Type of Pump _____)	
Position During / After Feeding		
Venting the G-Tube	☐ Yes ☐ No ☐ Before feeds ☐ After feeds ☐ Continuous	
Water Bolus Via G-tube	☐ Yes ☐ No Amount _____ ml Frequency _____	
Water Flush	☐ Yes ☐ No Amount _____ ml Frequency _____	
	☐ G-Tube ☐ J-Tube	
Pause or Hold Feeds	☐ Toileting ☐ Position Changes ☐ Gagging/ Retching ☐ Bus Ride	
Oral Feeding Restrictions/ instructions including any volume restrictions		
Additional Considerations in a 72-hour emergency		

If Tube is displaced at school, cover and (Check all applicable boxes). ☐ Parent and/or legal guardian has been trained to replace tube
☐ Child must see their doctor or surgeon for reinsertion of the tube.

Other instructions: _____

Duration of order(s): ☐ School Year ☐ (mm/dd/yr) _____ to _____.

Health Care Provider's Signature _____ Phone _____ Fax _____

Health Care Provider's Printed Name or Stamp _____ Date _____

To Be Completed by the Parent or Legal Guardian

Feeding Tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes.

I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child, *(name of child)* _____, the treatment prescribed by *(name of health care provider)* _____ for the _____ school year. 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.

Parent/Guardian Signature: _____ Date: _____

Phone Contacts: *Home* _____ *Cell* _____ *Work* _____ *Other* _____