Nixa Schools Health Services

Tube Feeding and Gastrostomy Medical Management and Treatment Plan

This page should be completed by the parent/guardian.

Student Name_____DOB_____School_____

Parent Name_____Home_____Work_____Cell_____

Parent Name_____Home_____Work_____Cell_____

Emergency Contact_____Relationship_____Phone_____

Physician Name_____Phone_____Preferred Hospital_____

<u>Permission to Administer Tube Feeding</u>

I give permission for the Nixa school nurses to administer my student's required tube feedings.

☐ Yes ☐ No

My student can competently administer required tube feeding.

☐ Yes* ☐ No

**The Nixa school nurses reserve the right to have the student demonstrate proper tube feeding technique and understand the function of the tube feeding before allowing administration.*

<u>Authorization to Release Medical Information</u>

I hereby give authorization to release/receive information regarding _____ (student's name) between Dr._____(physician/clinic) and _____ School including specific and confidential data to assist in the delivery of health care services to my child while at school.

Parent/Guardian Signature_____Date_____

School Nurse Signature_____Date_____

Nixa Schools Health Services

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Authorized Orders to be completed by Medical Provider

Student Name_____DOB_____

Gastrostomy Tube Feeding Authorized Orders

Type of Feeding Device

Gastrostomy tube type_____Size_____Adjusted Length_____

Gastrostomy button: ☐ MicKey ☐ Bard ☐ Other_____

Jejunostomy tube type_____Size_____

Tube Feeding Instructions

Formula type_____Amount_____Time/Rate_____

Feeding Method: ☐ Syringe Bolus (Gravity or Push) ☐ Slow drip from bag (Rate_____)

☐ Drip from pump (Rate_____) ☐ Portable pump (Rate_____)

Water amount before feeding_____ Water amount after feeding_____

Tube/Button Emergency Care

In the event the tube/button becomes dislodged:

☐ RN replace ☐ Call parent/doctor to replace ☐ Additional instructions_____

Oral Feedings

☐ NPO ☐ Tiny tastes of food/liquid ☐ Thin liquids ☐ Thick liquids (Nectar or Honey) ☐ Pureed foods

Additional Comments/Instructions

_____

_____

_____

Prescriber Signature_____Date_____

Prescriber Name (Printed)_____Phone_____Fax_____

ALL changes in required feeding doses administered during the school day require written instruction from the authorized prescriber.