



Health Care Provider Authorization and Recommendations for

Assisted Gastrostomy (G) or Gastrojejunostomy (GJ) Tube Feedings

Student's name: _____ Birthdate: _____

School: _____ Grade: _____

Student's diagnosis: _____ Allergies: _____

This is to certify that the above named student is under my care and needs to receive gastrostomy or gastrojejunostomy tube feedings during school hours as ordered below. I understand that some of these feedings may be administered by medically unlicensed school staff that will be trained and monitored by a school nurse. (*Note: If student is also receiving assisted oral feedings, please complete both provider forms for the school - #5335.02 F1 and #5335.02 F2.)

Type of Feeding Tube

Gastrostomy (G) size _____ Gastrojejunostomy (GJ) size _____

Feeding Type/Diet

Solution _____ Amt _____ mL freq _____
TYPE Pump (rate _____) Bolus (over _____ min) Gravity (over _____ min/hrs)

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Solution _____ Amt _____ mL freq _____
TYPE Pump (rate _____) Bolus (over _____ min) Gravity (over _____ min/hrs)

Give _____ mL of free water _____ a.m. and/or _____ p.m.
 PRN _____

Parent may provide premixed solution to school

Procedure for Administration

Positioning

- sitting upright during feeding and for _____ (min) after feeding is complete
- semi-reclined with head elevated to _____ degrees during feeding and for _____ (min) after feeding is complete
- side lying, Rt lateral with head elevated to _____ degrees during feeding and for _____ (min) after feeding is complete

Student's name: _____ DOB: _____

Residual

- Check residual
 - If greater than ____ mL
 - Feed
 - Delay feed
 - Recheck residual in _____ minutes. If residual greater than ____ mL, hold feed and contact parents.
 - Do not feed
- Do not check residual

Flush

- Flush
 - Before feeding with ____ mL of free water.
 - After feeding with ____ mL of free water.
- Do not flush

Vent

- PRN Please list indications for this student: _____

Complications

If gagging, nausea, coughing, and/or abdominal cramping

- Slow down rate of feeding and monitor. If no vomiting or other signs of cramping, continue feeding at slower rate.
- Stop feeding.
- For feeding via pump – stop pump.

If vomiting

- Stop feeding immediately.

Tube Displacement (must be completed)

- Position flat on back semi-reclined with head elevated to ____ degrees
 Rt lateral with head elevated to ____ degrees other _____
- Cover site with sterile gauze. Keep dry.
 - If parent and/or parent designee cannot arrive to school within ____ min / ____ hrs, call 911. District staff will not reinsert tube.

Additional Instructions

Beginning date for order: _____ Ending date for order: _____

Prescriber's signature: _____ Office #: _____

Prescriber's printed name: _____ Fax #: _____

Office address: _____

Parent/guardian signature: _____ Date: _____