

**RICHMOND CITY PUBLIC SCHOOLS HEALTH SERVICES
PHYSICIAN'S ORDER FOR GASTROSTOMY TUBE FEEDINGS AT SCHOOL**

STUDENT'S NAME: _____ **DOB:** _____

SCHOOL _____ **SCHOOL YEAR** _____

ALLERGIES: _____

DIAGNOSIS (REASON FOR TUBE FEEDING): _____

TYPE OF GASTROSTOMY APPLIANCE PLACED:

☐ PEG ☐ BUTTON ☐ G-TUBE ☐ OTHER _____ **SIZE:** _____

DATE AND SITE OF TUBE PLACEMENT: _____

THE TREATMENTS NEEDED DURING SCHOOL HOURS ARE

☐ FEEDING BY GRAVITY ☐ FEEDING BY PUMP **TYPE OF PUMP:** _____

☐ **G-TUBE MEDICATIONS to be administered at school:**

MEDICATION NAME	DOSE	FREQUENCY	TIME

PROCEDURE FOR FEEDING ADMINISTRATION:

1. POSITION STUDENT:

- ☐ 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. ASPIRATE:

- ☐ **I DO** order to check for aspirate: If aspirate is greater than _____ cc:
- ☐ FEED ☐ Delay feeding for _____ minutes and repeat aspiration ☐ **DO NOT FEED**
- ☐ If aspirate is greater than _____ cc, contact parent.
- ☐ **I DO NOT** order to check for aspirate.

3. FLUSHING:

- ☐ **I DO** order G-Tube to be flushed: ☐ **BEFORE** feeding or medication with _____ cc of water.
- ☐ **AFTER** feeding or medication with _____ cc of water.
- ☐ **I DO NOT** order G-Tube to be flushed.

4. PLEASE SPECIFY DIET/FLUID: TYPE/NAME OF FORMULA: _____

AMOUNT _____ RATE (if pump): _____

Frequency of feedings during school day: _____

Please give _____ cc of FREE WATER at (time/frequency) _____

5. IF G-TUBE DISLODGES AT SCHOOL: ☐ Cover site with clean gauze and promptly notify parent.

Please Note: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication and perform procedures.

Physician Signature: _____ **Date:** _____

Physician Name Printed: _____ **Phone :** _____

Parent's (Guardian's) Signature: _____ **Date:** _____

*Must be updated each school year