TUBE FEEDING ORDERS

Student Name: _____ Date of Birth: _____

BOLUS

Formula Name: _____

Amount: _____

Times: _____

Flush Amount _____

CONTINUOUS

Formula Name: _____

Amount: _____

Rate: _____

Time(s): _____

Flush Amount: _____

Special Instructions: _____

_____

Oral Feeding --- Please Check: YES_____ (If YES, complete DIET form) NO_____

Swimming Permission: YES_____ NO _____

How Long before Feeding Ostomy site closes? _____

PLEASE NOTE: School Personnel are unable to re-insert feeding tube. Parents will be notified immediately if feeding tube comes out.

Physician/ Licensed Health Care Clinician Name (printed) _____

Phone (_____) _____ Fax (_____) _____

Address_____

CLINICIAN SIGNATURE_____ Date_____

PARENT/GUARDIAN PERMISSION:
I hereby give my permission for the school nurse or trained school employee(s) to carry out the above orders for my child (named above) during school hours.

PARENT/GUARDIAN SIGNATURE: _____Date_____

School Nurse Signature: _____Date_____