



Lexington County School District One
Enteral Feeding
Medical Orders
School Year: _____

For school use only:
☐ Routine
☐ PRN (As needed)
Start Date: _____
D/C Date: _____

By signing this form, the parent/guardian and health care practitioner acknowledge that information provided on this form may be included in the student's Individual Healthcare Plan (IHP). Medications and/or treatments may be administered by an unlicensed, trained district employee.

Student Name		DOB	Grade	School
Diagnosis:		ICD-10 Code:		
Type of Feeding Port:			Tube Size:	
Gravity ☐ Syringe push ☐ Pump (bolus) ☐ Pump (continuous) ☐	Name of Formula:	Amount to be given:	Frequency:	
Flush:(type) Flush before, amount: _____ Flush after, amount: _____ Additional: _____	Check for residuals: Yes ☐ Time: _____ No ☐ Hold feeding for _____ Hold tube feeding for _____ hour/hours. May restart feeding when residual is _____	Is the student NPO? Yes ☐ No ☐ Liquids Yes ☐ No ☐ Amount _____ Thickening Yes ☐ No ☐	Is suctioning needed for this student? Yes ☐ No ☐ Suctioning type: _____ Suctioning frequency: _____	
Additional Oral Feedings Yes ☐ No ☐ Amount _____ Texture _____	Does the tube need to be burped/ left open to air post feeding? Yes ☐ No ☐ If Yes, for how long? _____	Additional instructions for suctioning	Additional instructions for ostomy care	

Reinsert tube for dislodgement? Yes ☐ **No** ☐ **Instructions for dislodgement/when to contact Health Care Practitioner:**

Health Care Practitioner Name _____ **Date** _____

Health Care Practitioner Signature _____

Phone _____ **Office Nurse's Name/other contact for questions** _____

I give permission for the treatments above to be administered as prescribed. I give permission for the school nurse to contact the health care practitioner named above and/or their designated employees to provide information about these orders and my child's health to the school nurse. I also give permission for this form to apply if I transfer my child to another school in Lexington County School District One during the current school year. I understand the school district and its employees and agents are not liable for an injury arising from administration of medication/treatments authorized by an IHP. I agree to indemnify and hold harmless the district and its employees and agents against a claim arising from administration of medication/treatments authorized by an IHP. I agree to notify the school if my child's health condition changes.

Parent/Guardian Name _____ **Date** _____

Parent/Guardian Signature _____

Phone (home) _____ **(work)** _____ **(cell)** _____