



G-TUBE FEEDING ORDERS 2025-2026

Name: _____	Birth Date: _____	
School: _____	Grade: _____	

MEDICATION/TREATMENT ORDERS: *Can be filled out by licensed health care provider; MD, DO, ND, DMD, DC, PA, ARNP, CNM. IHP can be filled out by School Nurse based on BSD "Medication Authorization Form – 3416P Exhibit A" or other completed provider orders. *In accordance with RCW 18.79.040, if a registered nurse is on site, they may utilize the nursing process, which includes assessment, specialized knowledge, judgment, and skill in determining plan of care or treatment.*

LICENSED HEALTH CARE PROVIDER ORDER FOR G-TUBE FEEDING ADMINISTRATION:

- Feeding by gravity Feeding by pump – Type of Pump: _____ Feeding by syringe/bolus

PROCEDURE FOR FEEDING ADMINISTRATION:

1. Position Student:

- Sitting upright Semi-reclining at _____ degree angle
- Lying on right side with head elevated at _____ degree angle
- Other: _____
- Remain upright for _____ minutes afterwards

2. Aspirate

- I DO NOT order to check for aspirate
- I DO order to check for aspirate. If aspirate is greater than _____ cc contact parent.

3. Flushing:

- I DO NOT order for G-tube to be flushed.
- I DO order G-tube to be flushed:
 - BEFORE feeding or medication with _____ cc's of water
 - AFTER feeding or medication with _____ cc's of water

4. Please specify diet/fluid:

- Type/name of feeding: _____ Amount: _____
- Rate: _____
- Frequency of feeding during the school day: _____
- Other orders: _____

5. Change or orders

- I DO NOT give parent/guardian permission to modify the orders.
- I DO give parent/guardian permission to modify the orders (method of delivery, position, aspirate, flushing, type of formula, rate and volume of formula and/or water) *without* contacting the health care provider.

*** PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication.** *In accordance with RCW 18.79.040, if a registered nurse is on site, he/she may utilize the nursing process, which includes assessment, specialized knowledge, judgment, and skill in determining plan of care or treatment.*

Licensed Health Care Provider's signature: <small>Signature authorizes medication for length of school year</small>	Date:		Phone:	
	School year:		Fax:	

PARENT/GUARDIAN/STUDENT (age 18 and older) RESPONSIBILITIES:

G-tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes. It is the responsibility of the parent and Health Care Provider to plan for safe replacement during the school day or school activities. Replacement options may include:

- Parent and/or family member will come to school within the hour or time specified by the Health Care Provider.
- Parent will arrange for medical appointment and/or transportation to Health Care Provider.
- Arrangement of an Emergency Contact to be used if parents cannot be located.
- I will notify the school nurse of any changes in health status or healthcare provider instructions.
- I understand that a procedure will not begin until adequate training of qualified staff is completed. Procedure may be delayed or missed due to unexpected circumstances or changes in the student's schedule.
- I understand that I must provide all necessary supplies and equipment to perform this service. I will keep track of expiration dates and quantity of the formula.
- I have been advised that a 3-day emergency supply should be provided to the school.
- If my student attends extended day/childcare, clubs before- and after-school, evening, and summer activities, I will notify the program director of my child's medication and health care needs.

I agree to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of any injury resulting from reasonable and prudent administration of medication, the reasonable performance of health care procedures, or the liabilities arising out of self-administration and self-carrying of medication by my student/me. BSD staff have been trained to assist with medication administration.

I accept this Individual Health Plan. My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.

Parent/Guardian/Student (age 18) signature: _____	Date:		Phone:	
			Fax:	

INDIVIDUAL CONSIDERATIONS:

Classroom:

- Teacher to inform substitute teachers of the student's Individual Health Plan

Field Trip Procedures: If your student does NOT self-carry, medication and IHP will accompany student during any off-campus activity. Student who self-carry are responsible for their own medication.

School Nurse: Will notify teachers, other school staff, transportation, and nutrition services of student's IHP

Please return to:

School Nurse: _____	Email:	_____@bsd405.org	Phone:	425-456-_____
			Fax:	425-456-_____

Updated 3/3/25

See also BSD Policy/Procedures: 2410 Student Health; 3411 Life Threatening Health Conditions; 3413 Student Immunization and Life-Threatening Health Conditions; 3416 Medication at School; 3418 Emergency Treatment
 Other resources: https://www.elmbrookschools.org/uploaded/SSMigration/data/files/gallery/Health_Services_Documents/Gtube_form_2015.pdf;
<https://www.lfcd.org/wp-content/uploads/2017/04/Parent-Packet-G-Tube-English.pdf>;
<https://resources.finalseite.net/images/v1524134790/nsdorg/mcmOfmtiwyywpladqve/health-procedure-and-nursing-care-authorization.pdf>;
<https://www.gcsc.k12.in.us/wp-content/uploads/2022/06/2022-2023-Tube-Feeding-Order.pdf>;
https://resources.finalseite.net/images/v1686833441/jcschoolsorg/kopx6rqxat9xsa7btuun/23_24GTube_Feeding_Physician_Orders.pdf