

HEALTH SERVICES DEPARTMENT
JEFFERSON PARISH SCHOOLS
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GASTROSTOMY FEEDING PROCEDURE ORDERS

School Year 20____/20____

Please print or type:

SCHOOL: _____

CHILD'S NAME: _____

DOB: _____

DIAGNOSIS: _____

Significant Health History: _____

Oral Feedings: Yes _____ No _____

If yes, what foods/liquids are to be taken at school? _____

Gastrostomy Feeding:

1. Type of feeding: Formula _____ Amount _____ Time _____

2. Amount of water to follow feeding: _____

3. Method of feeding: Bolus _____ Slow Drip _____

Pump _____ Setting _____

4. Feeding to be administered over _____ minutes

5. Venting as needed to relieve discomfort: Yes _____ No _____

6. Nissan Fundoplication: Yes _____ No _____

7. Type of device: Button _____ Mic-Key _____ Other _____

8. Special instructions: _____

Order Date _____

End Date _____

(Please consider summer school and summer camp)

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S NAME _____

ADDRESS _____

PHONE _____

FAX _____