

# G-Tube Feeding Order Form for School Feedings

Student: \_\_\_\_\_

ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_

Grade: \_\_\_\_\_

School Year: \_\_\_\_\_

## TYPE OF FEEDING DEVICE

☐ Gastrostomy tube

Type: \_\_\_\_\_

Size: \_\_\_\_\_ Adjusted tube length \_\_\_\_\_

☐ Gastrostomy button

☐ MicKey

☐ Bard

☐ Other: \_\_\_\_\_

☐ Jejunostomy tube or ☐ Gastro-jejunostomy tube

Type: \_\_\_\_\_

Size: \_\_\_\_\_ Fr \_\_\_\_\_

cm

## FEEDING METHOD

☐ Bolus

☐ Gravity drip

☐ Pump

Type of pump: \_\_\_\_\_

Flow Rate: \_\_\_\_\_ cc/hr

Flush tube with \_\_\_\_\_ cc water after feeding

## FORMULA FEEDING

Type: \_\_\_\_\_

Amount: \_\_\_\_\_

Time(s): \_\_\_\_\_

## WATER

Amount before feeding: \_\_\_\_\_

Amount after feeding: \_\_\_\_\_

Other: \_\_\_\_\_

## RESIDUAL

☐ Residual check not necessary

☐ Check residual:

Feed if residual < \_\_\_\_\_ Hold if residual > \_\_\_\_\_

☐ Further instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Note to Healthcare Provider & Parent/Guardian:

*The parent/guardian will be notified if tube becomes clogged or dislodged. School personnel cannot forcefully flush or replace a tube into the stomach.*

## ORAL FEEDINGS

☐ NPO (Nothing by mouth)

☐ Other\*: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*All oral feeding diets must be coordinated through nutrition services (253-945-5555) or the school's Speech & Language Pathologist

Additional healthcare provider comments: \_\_\_\_\_

\_\_\_\_\_

## Authorized Healthcare Provider's Authorization for Management of Gastrostomy Feeding in School

My signature below provides authorization for the above written orders. I accept responsibility for monitoring that adequate, safe arrangements are made for the performance of the above service. I may be called by school personnel regarding the above recommendations. I will be monitoring the ongoing health status of this patient. I understand that specialized physical health care services may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This authorization is for a maximum of 1 year. If changes are indicated, I will provide new written authorization.

Provider Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Duration of order: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Parent/Guardian Consent

I request that the above treatment be performed for my child by Federal Way School District personnel. It is my understanding that this treatment must be performed during school hours to enable my child to attend school. I also understand that this service may be provided by non-medical personnel after appropriate training. I agree to supply and any all necessary equipment ready for use and to notify the school nurse of any changes in my child's health status.

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_