

**Johnson City Schools
Health Services
Physician Order for Tube Feeding**

PARENT/GUARDIAN

Name: _____ Date of Birth: _____ School Year: _____
School: _____ Grade: _____ Teacher/Homeroom: _____
Parent/Guardian: _____ Phone: _____ Email: _____
Address: _____ City/State/Zip: _____
Secondary Contact: _____ Phone: _____

Medical Information

If medications are to be administered via feeding tube please complete separate medication administration form.

Invalid if altered by anyone other than child's provider.

Type of Feeding tube: _____ ☐ **Feed by gravity** ☐ **Feed by pump** ☐ **Feed by Bolus**

- 1. POSITION OF STUDENT-** ☐ Sitting upright or semi-reclining with head at _____ degree angle - OR -
☐ Lying on right side with head elevated at _____ degree angle - AND -
☐ Remain elevated for _____ minutes after feeding is administered

2. RESIDUAL- ☐ I DO order to check for residual If residual is greater than _____ cc, ☐ Feed ☐ DO NOT feed. Delay feeding for _____ minutes, and repeat residual. *If residual continues to be greater than _____, contact parent.
☐ I DO NOT order to check for residual

3. FLUSHING- ☐ I DO order tube to be flushed ☐ Before feeding or medications with _____ cc of free water
☐ After feeding or medications with _____ cc of free water
☐ I DO NOT order tube to be flushed

4. PLEASE SPECIFY DIET - that will be given during school day: Type of Feeding: _____
Amount: _____ Frequency of feedings during school day: _____
☐ It is ok for parent/guardian to direct changes in frequency/amount/times of feedings
☐ Please give _____ of free water at (indicate time) _____ AM and/or _____ PM

5. VENTING OF FEEDING TUBE ☐ I DO order for tube to be vented for the following symptoms: _____
☐ I DO NOT order feeding tube to be vented.

6. DISLODGED TUBE: ☐ I DO order for tube to be replaced
☐ I DO NOT order tube to be replaced.

Nurse or trained school personnel will reinsert the g-tube and cover device. Parent will be contacted immediately. Parent to reinflate balloon and complete the first feeding or medication administration after reinsertion. Nurse or trained school personnel will not reinflate balloon.

7. Is the student allowed oral feedings? ☐ Yes ☐ No If yes, Type: _____
Frequency: _____ Side effects to be reported: _____

Comments: _____

Healthcare Provider Name/Title

Healthcare Provider Signature

Date

Phone Number

Fax number

Email

I authorize this procedure be performed by the nurse or the nurse's designee as directed above. It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all supplies needed for the procedure. New forms must be completed annually or with any changes in the student's health status. The nurse or trained school personnel has permission to communicate with the healthcare provider regarding this procedure and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the healthcare provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Johnson City School System, the undersigned parent or guardian hereby understands and agrees that the Johnson City School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication. Should the feeding tube become dislodged, I will be immediately contacted by school personnel. By signing, parent indicates agreement with the orders as described by healthcare provider.

Parent/Guardian Signature

Printed Name

Date