



GASTROSTOMY TUBE FEEDING FORM

This form must be completed by a licensed healthcare provider.

Student Name: _____ DOB: _____

Type of Gastrostomy Appliance Placed: _____

Last Changed: _____ Balloon Volume: _____

Formula Type: _____

Formula Delivery Method: ☐ Pump ☐ Gravity/Bag Syringe: ☐ Gravity ☐ Push

Rate (if pump): _____

Volume: _____ Frequency: _____

Residuals Checked? ☐ Yes ☐ No Protocol to follow if residual is over _____ cc

Residual Protocol to Follow: _____

Flushing Protocol: _____

Venting Frequency: _____ Duration: _____

Medication given via gastrostomy during school hours: ☐ Yes ☐ No

***If medication is prescribed, a Medication Administration Authorization Form is required.**

Oral feedings in addition to gastrostomy: ☐ Yes ☐ No ☐ NPO

If yes, please describe: _____

Tube/ Button Dislodgement Protocol: In the event the gastrostomy tube button becomes dislodged, the site will be covered, and the parent/guardian will be notified immediately.

Licensed Provider Authorization:

Provider Name: _____

Provider Signature: _____ Date: _____

Parent/Guardian Authorization:

By signing below, I give permission for school healthcare personnel to administer my student's gastrostomy feeding and care according to the provider order above. I also acknowledge that I am responsible for providing all supplies required for gastrostomy care, while my student is at school, and for updating the school nurse with the most up to date orders from the licensed healthcare professional.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____