PHYSICIAN ORDER FOR TUBE FEEDING

Student Name: _____ **DOB:** _____

School Name: _____ **Allergies:** _____

- The student's licensed health care prescriber must complete and sign section 1 of this form
- Parent/guardian must sign the bottom of this form in section II at the beginning of each school year.
- This completed form must be on file in the student's health record before a trained staff member can administer anything through the tube.

I. Prescriber's section

Prescriber's name/title (printed): _____ Phone: _____

PLEASE SPECIFY DIET *(that will be given during school day)*:

Type of tube: ☐ G-tube ☐ G-J tube ☐ Other: _____

Type of formula/feeding: _____ Amount (ml): _____

Which port should formula/medications be administered through *(if applicable)*: _____

Time(s) during the school day to administer feeding: _____ _____ _____

☐ Continuous feed **If continuous, OK to unhook for therapy/swimming? _____

DELIVERY TYPE:

☐ Feeding by gravity (bag) **If given by gravity bag, how often should new bag be used?_____

☐ Feeding by bolus (syringe) ** If given by bolus/gravity, infuse no faster than_____ cc per_____ mins

☐ Feeding by pump **If given by pump, specify pump settings _____ml/hr

FLUSHING: *(indicate which port to use if applicable)*

☐ Before feeding/med w/_____cc

☐ After feeding/med w/_____cc

☐ Between meds that are given at same time, w/ _____cc

Comments/special instructions: _____

_____

****Please note if the tube becomes dislodged from the stoma this is the parent's responsibility and school staff are not responsible for replacing a dislodged tube.**

Prescriber's signature/title: _____ **Date:** _____

II. I hereby request a trained staff member to administer the above procedure and/or medication(s) according to the physician's instructions as listed above. *I agree to furnish all equipment, supplies, medication or other necessary items and replenish as needed*

Parent/Guardian signature: _____ **Date:** _____