



PHYSICIAN ORDER FOR G-TUBE FEEDING HEALTH CARE PLAN

To be completed by the student's Physician, signed by parent, and returned to school, Attn: School Nurse

STUDENT'S NAME: _____ DOB: _____

SCHOOL: _____ SCHOOL YEAR: _____

ALLERGIES: _____ TYPE OF FEEDING TUBE: _____

THE TREATMENTS NEEDED DURING SCHOOL HOURS ARE: (please indicate):

- Feeding by gravity Feeding by pump
- G-tube medications – Please list drug, dosage and frequency: _____

PROCEDURE FOR FEEDING ADMINISTRATION:

1. POSITION 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. ASPIRATE – Check one:

- I DO order to check for aspirate
- If aspirate is greater than _____ cc, Feed DO NOT feed
- _____ Delay feeding for (____) minutes, and repeat aspiration.
- ***If aspirate continues to be greater than _____, contact parent.

3. FLUSHING – Check one:

- I DO order G-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 G-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. DIRECTIONS FOR DISLODGED G-TUBE:

6. COMMENTS:

Physician's Signature

Date

Physician's Name (printed)

Telephone Number

***PLEASE NOTE: The School Nurse is NOT always in the school building and trains non-medical staff to administer medication.**

PARENT/GUARDIAN STATEMENT

I, the undersigned Parent/Guardian of _____, hereby request the School Nurse or trained staff member to administer the above procedure(s) and medication(s) according to the Physician's instructions. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance, as necessary.

I agree to notify the School Nurse immediately if there is any change in the student's status or Physician's orders. Physicians orders need to be renewed every school year OR when changes are made to care plan.

Parent/Guardian Signature: _____ Date: ____/____/____

Home Phone: _____ Work: _____ Cell: _____

Reviewed by: _____, RN Date: _____