



LICENSED HEALTH PROVIDER'S FEEDING TUBE PROCEDURE REQUEST AT SCHOOL

Student Name _____ Birthdate _____

School _____ Grade _____

TO BE COMPLETED BY A LICENSED HEALTH PROVIDER WITH PRESCRIPTIVE AUTHORITY

Type of Feeding Tube	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> GJ-Tube	Brand/ Profile _____ Inflate _____
Method of Delivery- Feeding	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube	
Method of Delivery- Medications	<input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube <input type="checkbox"/> Other _____	
Formula Name/ Recipe	_____ Prepared by family <input type="checkbox"/> Yes <input type="checkbox"/> No	
Feeding Infusion Rate	_____ ml/hr Parent can adjust rate <input type="checkbox"/> Yes <input type="checkbox"/> No No slower than _____ ml/hr ; No faster than _____ ml/hr	
Frequency or Duration	<input type="checkbox"/> Continuous Feed _____ hrs/day <input type="checkbox"/> Bolus/Total volume _____ ml Times of feeding _____ Parent can adjust timing <input type="checkbox"/> Yes <input type="checkbox"/> No Parent determined time(s) _____	
Feeding Method	<input type="checkbox"/> Bolus <input type="checkbox"/> Gravity <input type="checkbox"/> Pump (Type of Pump _____)	
Position During / After Feeding		
Venting the G-Tube	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Before feeds <input type="checkbox"/> After feeds <input type="checkbox"/> Continuous	
Water Bolus Via G-tube	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____ ml Frequency _____	
Water Flush	<input type="checkbox"/> Yes <input type="checkbox"/> No Amount _____ ml Frequency _____ <input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube	
Pause or Hold Feeds	<input type="checkbox"/> Toileting <input type="checkbox"/> Position Changes <input type="checkbox"/> Gagging/ Retching <input type="checkbox"/> Bus Ride	
Oral Feeding Restrictions/ instructions including any volume restrictions		
Additional Considerations in a 72-hour emergency		

If Tube is displaced at school, cover and (Check all applicable boxes). Parent and/or legal guardian has been trained to replace tube
 Child must see their doctor or surgeon for reinsertion of the tube.

Other instructions: _____

Duration of order(s): School Year (mm/dd/yr) _____ to _____

Health Care Provider's Signature _____ Phone _____ Fax _____

Health Care Provider's Printed Name or Stamp _____ Date _____

To Be Completed by the Parent or Legal Guardian

Feeding Tubes that become dislodged or fall out: Please be aware that school staff do not have universal training to replace G-tubes.

I request that the school nurse or designated staff member be permitted to discuss my child's medical issues with health care providers, and administer to my child, *(name of child)* _____, the treatment prescribed by *(name of health care provider)* _____ for the _____ school year. I understand that my signature indicates my understanding that the school accepts no liability for untoward reactions when the treatment is administered in accordance with the health care provider's directions. **I will collect any necessary supplies and equipment from the school at the end of the year or understand that it will be discarded.** I am the parent or the legal guardian of the child named.

- I will notify the school immediately with any changes or cancellations.
- I understand that a procedure will not begin until adequate training of qualified staff is completed.
- I understand that I must provide all necessary supplies and equipment to perform this service.

Parent/Guardian Signature: _____ Date: _____

Phone Contacts: *Home* _____ *Cell* _____ *Work* _____ *Other* _____