

## Health Care Provider Order for Tube Feedings at School - 2020-2021 School Year

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Feeding by gravity       Feeding by pump      Type of Feeding Tube: \_\_\_\_\_

### 1. Position Student

- Sitting upright or semi-reclining with head at a \_\_\_\_\_ degree angle.
- Remain elevated for \_\_\_\_\_ minutes after feeding is administered.
- Other: \_\_\_\_\_

### 2. Aspirate

- I **do** order to check for aspirate. If aspirate is greater than \_\_\_\_\_ mL:
  - Continue with feed and document aspirate volume.
  - Delay feeding for \_\_\_\_\_ minutes and repeat aspiration.
  - Do not feed and notify parent.

Notify parent if aspirate volume is greater than \_\_\_\_\_ mL.

- I **do not** order to check for aspirate prior to feeding.

### 3. Flushing

- I **do** order tube to be flushed:
  - Before feeding or medication with \_\_\_\_\_ mL of water.
  - After feeding or medication with \_\_\_\_\_ mL of water.
- I **do not** order tube to be flushed.

### 4. Please specify diet/fluid:

Type/Name of Formula: \_\_\_\_\_ Volume: \_\_\_\_\_ mL

Rate (if pump): \_\_\_\_\_ Time(s): \_\_\_\_\_

- Please give \_\_\_\_\_ mL of free water at: \_\_\_\_\_

Up to \_\_\_\_\_ mL of free water can be given each school day per parent/guardian request on an as needed basis as determined by the parent and/or school nurse.

- 5.  The school nurse should attempt to replace the g-tube should it become dislodged at school. Should tube not be able to be reinserted, cover with clean gauze and notify parent immediately. Instructions for replacement are to be provided by the healthcare provider along with this order.

The school nurse should not attempt to replace the g-tube should it become dislodged. The stoma should be covered with clean gauze and the parent notified immediately.

\_\_\_\_\_  
Healthcare Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone Number

I request that school personnel administer the above procedure as prescribed by the health care provider. I certify that I have legal authority to consent to medical treatment for the student named above. I authorize school nursing staff to communicate with the prescribing health care provider regarding this student's medical condition. I agree to furnish all equipment, supplies, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_