School:______________________________ School Year:____________________

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:____________________________

ALLERIGIES:____ 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:____________________________