Physician Order for G-Tube Feeding

Individual Health Care Plan

Student Name:	**Grade:**	**Date of Birth:**

Physician Order	
Feeding Route:	_____ G-Tube _____ J-Tube _____ Other (Please list):
Formula Name:	
Method of Feeding:	_____ Gravity _____ Continuous Pump _____ Intermittent Pump
Rate of Feeding:	_____ ml/ hour _____ N/A (feeding to gravity) _____ Parent discretion
Amount / Volume:	_____ mL _____ Amount supplied by parent in pre-filled bag
Time/ Frequency to be Administered:	
Water Flush	_____ Yes, amount of free water: _____ mL before feeding _____ mL after feeding _____ No _____ Parent Discretion
Position:	Student will be in an upright position during feeding, and will remain upright for 30 min after their feed unless otherwise noted here. Note changes here:
Comments:	

Physician Authorization	
Physician Printed Name:	**Phone Number:**
Physician Signature:	**Date:**

Parental Consent /Acknowledgement

1. New prescription orders are due at the beginning of the school year, and expire the last day school and must include BOTH the physician and parent/guardian signature.
2. Written doctor's orders must be received stating: name g-tube feeding, dosage/amount, and time to be administered
3. The school nurse may obtain telephone orders from the prescribing physician for administration of medication until written orders are received.
4. I hereby give my permission for the school nurse, trained health room personnel, trained office staff or authorized trained school personnel to administer the g-tube feeding to my child according to the directions stated below.
5. I give my permission to the school nurse to contact the student's physician.
6. I further agree to hold the Arrowhead School District and the above-identified person(s) harmless in any or all claims arising from the administration of this feeding /medication or the performance of this procedure at school.
7. I agree to notify the health room at the termination of this request or when any change in the above orders is necessary.
8. I agree to supply the necessary medical supplies to school and monitor the need for more supplies.

Parent/Guardian Name:	**Parent/Guardian Signature:**	**Date:**