Physician Order form for G-Tube Feeding Procedure

To be completed by the students Physician and returned to Chilton Public School Nurse: FAX (920)849-9457.

STUDENTS NAME: ______________________________________ DOB: _______________________
ALLERGIES: ____

Treatments needed during school hours are (please indicate):

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

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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. **Flushing** – check one:
   - ☐ I DO order G-tube to be flushed after feeding/medications with ___ ml of free water
   - ☐ I DO NOT order G-tube to be flushed
3. **Please specify diet** that will be given during school days:
   Type of feeding: ____
   Amount of feeding: ____
   Frequency of feeding: ____
   *** Please give ____ of free water at (indicated time) ____AM and/or _____PM.
4. **Comments: -**
   ____
   ____
   ____

____ ___________________________
Physician's Signature Date

~ PLEASE NOTE: The school nurse is NOT always in the school building and trains non-medical staff to administer medication. We urge all instructions be stated in language of the lay person.

Parent/Guardian Statement

☐ I, 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 instruction. I agree to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure listed above. **I agree to notify the School Nurse if there is any change in the student's status or Physicians' orders.**

Parent/Guardian Signature: _________________________________ **Date:** ____________________

Home phone: _____________________ **Work:** ___________________ **Cell:** ____________________

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Reviewed by: _________________________________ RN Date: _________________________