Queen Creek Unified School District

Tube Feeding Order

To be completed by a Licensed Healthcare Provider (Physician, Physician;s Assistant, or Nurse Practitioner)

Student Name:_____ DOB:_____ Grade:_____ Year:_____

Provider name:_____ Phone Number:_____ Fax Number:_____

Type of Tube:
- ☐ G Tube
- ☐ NG Tube
- ☐ GJ Tube
- ☐ J Tube
- ☐ Size:_____
- ☐ Date Placed:_____

Method of Feeding:
- ☐ Pump
- *Type:_____
- *Prime with: _____
- ☐ Gravity
- ☐ Bolus

Type of Nourishment:
- ☐ Formula:_____
- ☐ Pureed Food:_____
- ☐ Other:_____

Steps to confirm placement:_____

Venting Required:
- ☐ Yes Frequency:_____
- ☐ No

Residual Checks:
- ☐ No
- ☐ Yes
- HOLD FEEDING if residual more than _____cc
- Subtract residual volume from feeding volume if residual is between _____ - _____cc

1st Feeding:

Time:_____ Amount:_____ Rate:_____ Flush:_____cc water after feeding

2nd Feeding:

Time:_____ Amount:_____ Rate:_____ Flush:_____cc water after feeding

Flush:

_____ cc of water before feeding

Medication to be mixed/given with feeding:
- ☐ Yes (See Provider Medication Form)
- ☐ No

Is student able to take anything by mouth at school:
- ☐ Yes How much:_____ How often:_____ Consistency:_____
- ☐ No

I am aware that the parent/ guardian will train the staff/ unlicensed assistive personnel to feed the student and reinsert the Gastrostomy button if it comes out at school. *If Gastrostomy button comes out at school, trained nurses, health assistants/ Unlicensed assistive personnel may reinsert a deflated and clean gastrostomy button to keep the stoma open and then call parents.*

Licensed Healthcare Provider Signature:_____ Date:_____

I agree with the above care plan and to provide the necessary equipment/ supplies properly labeled for use in school. I will train the staff/ unlicensed assistive personnel to administer the above procedure. I grant permission for the school staff to communicate directly with the above named provider, regarding this care plan. I will notify the school of changes in procedure or provider.

Parent/Guardian Signature:_____Date:_____ Phone:_____Health Aide/Nurse Signature:_____ Date:_____