Weber School District

Physician Order for Administration of Tube Feedings During School Hours

Student Name _____ DOB:_____

NG Tube ____G-Tube Type:_____

Nutritional Supplement/Formula Type:_____

Times/Frequency during the school day for tube feeding_____

Length of time for tube feeding:_____ amount to be administered_____

Feeding Method: ____bolus ___gravity ___pump (Specify type_____

Pump Rate:_____

Additional fluid requirements to flush or for hydration:_____

_____

Steps to confirm Feeding Tube Placement: __No __Yes _____

Check for Residual: __No __Yes (Specify _____)

Directions to follow should tube become dislodged:_____

_____

Conditions under which tube feeding should not be given:_____

_____

Additional Comments/Instructions:_____

Physician Signature:_____Date:___/_____/_____

Phone_____Fax:_____

Parental Permission to Administer Tube Feedings

___I give permission that the above tube feeding be given to my child by the nurse, and/or other trained school personnel, as prescribed by my child's physician.

Parent/Guardian Signature:_____Date___/____/_____