CMCSS Physician Orders and Parent Input for Tube Feeding at School

School Year 20__-20__ School: _____ Grade: _____

Student: _____ **Date of Birth:** _____ **Diagnosis:** _____

TYPE OF FEEDING DEVICE

❑ Nasogastric tube

❑ Gastrostomy tube
Type: _____
Size: _____

❑ Gastrostomy button
- ☐ MicKey
- ☐ Bard
- ☐ Other: _____

❑ Jejunostomy tube or ❑ Gastro-jejunostomy tube
Type: _____
Size: _____ Fr _____ cm

FEEDING METHOD

❑ Bolus/Syringe

❑ Gravity drip

❑ Pump
Type of pump: _____
Flow Rate: _____ cc/hr

Flush tube with _____ cc water
❑ before feeding
❑ after feeding
❑ Additional fluids if needed:
Type: _____
Amount: _____ Time(s): _____

FORMULA FEEDING

Type: _____

❑ Parent pre-mixed/prepared

Amount: _____

Time(s): _____

Position of student during feeding: _____

Further instructions: _____

ORAL LIQUIDS/FEEDINGS

❑ NPO (Nothing by mouth)

❑ Liquids only by mouth
Type: _____
Consistency: _____
Amount: _____ Time(s): _____

❑ Food type: _____
Consistency: _____
Amount: _____ Time(s): _____

RESIDUAL

❑ Residual check not necessary

❑ Check residual:
Feed if residual < _____ Hold if residual > _____

❑ Further instructions: _____

_____

INSTRUCTIONS FOR COMPLICATIONS

Alternative feeding option for pump malfunction:

_____

_____

Clogged tube: _____

Note to Healthcare Provider & Parent/Guardian: *The parent/guardian will be notified immediately if the tube becomes clogged or dislodged. If the parents/guardians are not available EMS will be called when necessary and upon the nurses' discretion.*

Authorized Healthcare Provider's Authorization for Management of Gastrostomy Feeding in School

My signature below provides authorization for the above written orders. I may be called by school personnel regarding the above recommendations. I will be monitoring the ongoing health status of this patient. This authorization is for a maximum of 1 year. If changes are indicated, I will provide new written authorization.

Provider Printed Name: _____ **Signature:** _____

Date: _____ **Duration of order:** _____ **Phone:** _____ **Fax:** _____

Parent/Guardian Consent

I request that the above treatment be performed for my child by CMCSS personnel. It is my understanding that this treatment must be performed during school hours to enable my child to attend school. I agree to supply all necessary equipment in properly working condition to the school nurse and to notify the school nurse of any changes in my child's health status. I agree to the release/obtaining of medical information to/from CMCSS for my child, named above. This information will remain confidential and is valid for the current school year listed above.

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