



Mecklenburg County Health Dept

SCHOOL HEALTH SERVICES
A Partnership for Serving Children

Order: Tube Feeding in School

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_
Student's Address: \_\_\_\_\_
Student's Phone #: \_\_\_\_\_ Student's I.D.: \_\_\_\_\_
Mother's Name: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_
Father's Name: \_\_\_\_\_ Phone: Work \_\_\_\_\_ Cell \_\_\_\_\_
Preferred Hospital: \_\_\_\_\_
School: \_\_\_\_\_ Teacher/Grade/Homeroom: \_\_\_\_\_
Student's Diagnosis: \_\_\_\_\_

Please have the student's Health Care Provider complete the following information:

- 1. Select method of G-tube feeding:
a. Bolus feeding of \_\_\_\_\_ / \_\_\_\_\_ over \_\_\_\_\_ minutes at \_\_\_\_\_ and \_\_\_\_\_ OR
b. \_\_\_\_\_ pump of \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ and \_\_\_\_\_ OR
continuous at \_\_\_\_\_ ml/hr.
2. Position student's head at 45° during feeding or as comfortable.
3. Flush with \_\_\_\_\_ cc water after feeding.
4. Keep student's head and chest elevated after feeding for \_\_\_\_\_ minutes.
5. Vent tube as needed.
6. Document feeding daily on procedure flow sheet.
7. Notify parent of any incident or change in feeding tolerance.
8. If tube becomes dislodged, cover tube site with gauze and secure with tape and CALL PARENT.
9. Other: \_\_\_\_\_

Duration of order: School Year: \_\_\_\_\_

Health Care Provider \_\_\_\_\_ Phone # \_\_\_\_\_ FAX # \_\_\_\_\_
Address: \_\_\_\_\_
Health Care Provider signature: \_\_\_\_\_
Date: \_\_\_\_\_

(Please sign here to authorize this order and return to the School Health Program, MCHD, Hal Marshal Annex, 618 North College Street, Charlotte, N.C. 28202 Fax: 704-432-2079 Attn: School Health.)

I have reviewed this order and give my permission for the School Health Nurse to train school personnel to follow this order.

Parent /Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I have provided training and instruction regarding this order to: \_\_\_\_\_
(Signatures of personnel trained)

School Health Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

