Loudoun County Public Schools
Tube Feeding Physician's Order

Place Student's Picture Here

Student's Information

Last Name: _____ First Name: _____ DOB: _____

Student ID #: _____ School: _____ Grade: _____

Parent/Guardian: _____ Cell: _____ SY: _____

TUBE FEEDING ORDER

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

Type of Tube:	**Methods of Feedings:**	**Student's condition requiring tube feedings:**
☐ G Tube ☐ GJ Tube	☐ Pump	_____
☐ NG Tube ☐ J Tube	☐ Gravity	**Student has had a Nissan Fundoplication:** ☐ Yes ☐ No
☐ Size: _____	☐ Push	

Order Requirements:

1. A new Healthcare Provider order is required for each school year and when a change has been made to the procedure.
2. Staff will complete the *Individual Feeding Log* after each feeding.
3. Parent/Guardian provides all supplies including an extra supply of formula to be kept in case of spillage/shelter in place.
4. Parent/Guardian may want to leave extra feeding extension tube and syringe at school.
5. If tube comes out, the parent/guardian will be called. LCPS staff WILL NOT reinsert it.
6. Parent/Guardian will give instructions and demonstration prior to first feeding in school.

PROCEDURE FOR FEEDING ADMINISTRATION:

Student position: Student should be fed sitting upright or semi-reclining and should remain upright for _____ minutes after feeding.

Venting required: ☐ Yes ☐ No Frequency: _____

Residual checks before feeding: ☐ Yes ☐ No

- HOLD FEEDING if residual is more than _____ mL
- Subtract residual volume from feeding volume if residual is between _____ - _____mL

Flushing: Tube should be flushed:

☐ Before feeding or medication with _____ mL water

☐ After feeding or medication with _____ mL water

Pump Unavailable:

☐ In the event the pump is unavailable (ie. malfunction, lack of equipment, etc.), bolus feeding may be given.

Medication to be mixed/given with feeding: ☐ Yes ☐ No (See Authorization for Medication Administration)

Tube feeding schedule during school hours (times may vary up to 30 minutes to meet school schedule)

Time:	**Formula/Solution/Liquid Name:** (including free water)	**Quantity To Be Fed:** (specify in mL's)	**Rate/Duration of Feeding:**	**Additional Information:**

(continued)

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Oral feedings: Does student require oral feedings in addition to tube feedings? ☐ Yes ☐ No

- If yes, please specify what can be consumed, consistency, amount, and feeding precautions: _____

_____

_____

Additional physician instruction:

_____

_____

Healthcare Provider's Name (Print/Stamp): _____

Healthcare Provider's Signature: _____ **Date:** _____

National Provider Identifier (NPI): _____ **Phone**: _____

Parent/Guardian Name (printed): _____

My signature gives permission for principal's designee to follow this plan, administer feeding, and contact healthcare provider if necessary. I also agree to pick up any unused supplies/formula at the end of the school year. I understand that supplies/formula not picked up by a parent/guardian at the end of the school year will be discarded.

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