**Student’s Information**

Last Name: ____________________  
First Name: ____________________  
DOB: __________

Student ID #: ____________________  
School: ____________________  
Grade: _______

Parent/Guardian: ____________________  
Cell: ____________________  
SY: _______

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**Tube Feeding Order**

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

<table>
<thead>
<tr>
<th>Type of Tube:</th>
<th>Method of Feeding:</th>
<th>Type of Nourishment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>G Tube</td>
<td>Pump</td>
<td>Formula: ____________</td>
</tr>
<tr>
<td>GJ Tube</td>
<td>Gravity</td>
<td>Pureed Food: _______</td>
</tr>
<tr>
<td>NG Tube</td>
<td>Push</td>
<td>Other: ____________</td>
</tr>
<tr>
<td>J Tube</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Size: _______ |

**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.

**Venting Required:** □ Yes □ No  
**Frequency:** ____________________

**Residual Checks:** □ Yes □ No

- HOLD FEEDING if residual is 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

**PRN Feeding:**

Time: ___________  
Amount: ___________  
Rate: ___________  
Flush: ___________ cc water after feeding

**Medication to be mixed/given with feeding:** □ Yes □ No  
(See Authorization for Medication Order)

**Water to be given between feedings:** □ Yes □ No

Time(s): ___________  
Amount: ___________  

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**Healthcare Provider’s Name (Print/stamp):** ____________________

**Healthcare Provider’s Signature:** ____________________  
**Date:** ___________

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

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**Parent/Guardian Name:** ____________________  
**Phone:** ____________________

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:** ___________