Dublin City School District

Health Care Provider Authorization and Recommendations for Assisted Gastrostomy (G) or Gastrojejunostomy (GJ) Tube Feedings

Student's name: _____ Birthdate: _____

School: _____ Grade: _____

Student's diagnosis: _____ Allergies: _____

This is to certify that the above named student is under my care and needs to receive gastrostomy or gastrojejunostomy tube feedings during school hours as ordered below. I understand that some of these feedings may be administered by medically unlicensed school staff that will be trained and monitored by a school nurse. (*Note: If student is also receiving assisted oral feedings, please complete both provider forms for the school - #5335.02 F1 and #5335.02 F2.)

Type of Feeding Tube

☐ Gastrostomy (G) size _____ ☐ Gastrojejunostomy (GJ) size _____

Feeding Type/Diet

☐ Solution _____ Amt _____mL freq _____
TYPE ☐ Pump (rate ____) ☐ Bolus (over ___ min) ☐ Gravity (over ___ min/hrs)

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☐ Give_____mL of free water ☐ _____ a.m. and/or _____ p.m.
☐ PRN _____

☐ Parent may provide premixed solution to school

Procedure for Administration

Positioning

☐ sitting upright during feeding and for _____ (min) after feeding is complete
☐ semi-reclined with head elevated to _____ degrees during feeding and for _____ (min) after feeding is complete
☐ side lying, Rt lateral with head elevated to _____ degrees during feeding and for _____ (min) after feeding is complete

Student's name: _____ DOB: _____

Residual

- ☐ Check residual
  - If greater than _____mL
    - ☐ Feed
    - ☐ Delay feed
    - ☐ Recheck residual in _____ minutes. If residual greater than _____mL, hold feed and contact parents.
    - ☐ Do not feed
- ☐ Do not check residual

Flush

- ☐ Flush
  - ☐ Before feeding with _____mL of free water.
  - ☐ After feeding with _____mL of free water.
- ☐ Do not flush

Vent

- ☐ PRN Please list indications for this student: _____
  _____

Complications

If gagging, nausea, and/or abdominal cramping

- ☐ Slow down rate of feeding and monitor. If no vomiting or other signs of cramping, continue feeding at slower rate.
- ☐ Stop feeding.
- ☐ For feeding via pump – stop pump.

If vomiting

- ☐ Stop feeding immediately.

Tube Displacement (must be completed)

Position ☐ flat on back ☐ semi-reclined with head elevated to ____ degrees
☐ Rt lateral with head elevated to ____ degrees ☐ other _____

- ☐ Cover site with sterile gauze. Keep dry.
- ☐ If parent and/or parent designee cannot arrive to school within ____ min / ____ hrs, call 911. District staff will not reinsert tube.

Additional Instructions

_____
_____

Beginning date for order: _____ Ending date for order: _____

Provider's signature: _____ Office #: _____

Provider's printed name: _____ Fax #: _____

Office address: _____

Parent/guardian signature: _____ Date: _____