HAMPTON CITY SCHOOLS HEALTH SERVICES
Enteral Feeding Orders
School Year: _____

STUDENT'S NAME (Last, First):	BIRTHDATE:	GRADE/ROOM

I. PHYSICIAN ORDER

DIAGNOSIS: _____
Type of gastrostomy device: _____ Size: _____
Insertion Date: _____ Was a fundoplication performed? ☐ YES ☐ NO
If tube is dislodged, how much time before stoma will close: _____

ORAL FEEDINGS:

☐ NO oral feedings or liquids
☐ Regular diet (oral)
☐ Soft diet (oral)
☐ Pureed diet (oral)
☐ Thickened liquids (oral); Specify: _____
☐ Other: _____

G-TUBE FEEDINGS:

☐ NO tube / button feedings at school
☐ Gravity feeding over period of _____ minutes
☐ Pump feeding at a rate of _____ cc/hour
☐ Flush with _____ cc water after feedings and medications

FORMULA: _____ Amount: _____

FREQUENCY:

☐ Once per day at school ☐ Twice per day at school
☐ Every _____hour(s) ☐ Other: _____

_____ _____
PRINT PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE

_____ _____ _____
PHYSICIAN'S ADDRESS PHYSICIAN'S PHONE NUMBER DATE

II. AUTHORIZATION AND CONSENT FOR SERVICES

I request and authorize the school nurse and trained school personnel to administer enteral feedings (tube feedings) as prescribed by my child's physician. I will provide the school with the necessary supplies/equipment to perform this service for my child. I will also provide written notification from the physician if the treatment changes or is discontinued. This authorization will be in effect for the above stated school year.

_____ _____ _____
PARENT'S/GUARDIAN'S NAME PARENT'S/GUARDIAN'S SIGNATURE DATE

III. AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I authorize the release of information about the specialized health care procedures/services related to my child's condition between the child's prescribing physician, the school nurse, and school personnel who care for my child and may need to know this information to maintain my child's health and safety. This authorization will be in effect for the above stated school year.

_____ _____ _____
PARENT'S/GUARDIAN'S NAME PARENT'S/GUARDIAN'S SIGNATURE DATE

IV. SCHOOL NURSE ACKNOWLEDGEMENT

_____ _____ _____
SCHOOL NURSE NAME SCHOOL NURSE SIGNATURE DATE